WELCOME TO BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

For employees of City of Sarasota

January 1,2025 through December 31,2025

MyHealthToolkitFL.com

INTRODUCTION

The City of Sarasota provides a comprehensive compensation package including group insurance benefits. The Benefit Guide provides a general summary of these benefit options as a convenient reference. Please refer to the City's Personnel Policies, applicable Union Contracts and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If you require further explanation or need assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources using the contact information provided. Information and descriptions provided are for the specific plan year and should not be construed as a contract.

Important Notices for Plan Participants & Beneficiaries

The Federal Government has outlined several notices as Important Notices for our medical plan participants:

- Children's Health Insurance Program Reauthorization Act (CHIP)
- HIPAA Notice of Privacy Practices
- Medicare Part D Creditable Coverage Notice
- Summary of Benefits and Coverage
- Women's Health and Cancer Rights Act of 1998
- Health Insurance Marketplace Coverage Notice

All of the above notices can be viewed in their entirety on the employee benefits website at **Sarasotafl.gov/government/human-resources**

Complete, printed copies can also be mailed direct to your home. Please send requests to:
Human Resources, 111 South Orange Avenue, Room 204, Sarasota, FL 34236 or call **(941) 263-6338**.

Eligibility Guidelines

Employee Eligibility

- Employees are eligible to participate in the employee benefits program as follows:
    - Medical, dental, vision, accident, critical illness, basic life, voluntary life, and legal if you work 30 or more hours a week.
    - Short term disability and long-term disability if you work a minimum of 40 hours a week.
    - Employee Assistance Program (EAP) is available to all employees
- Coverage will be effective the 1st of the month following the Date of Hire. For example, if you are hired on April 11th, your coverage will be effective on May 1st.
- City Commissioner's coverage will be effective the day they are sworn in.

Termination

If you separate employment from the City, insurance will end at midnight the day in which the separation occurred.

Dependent Eligibility

A dependent is defined as the participant's legal spouse or domestic partner and dependent child(ren) of the participant or domestic partner. Dependent children may be covered through the end of the calendar year in which the child reaches age 26 with no eligibility requirements. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A child placed for adoption
- A stepchild
- A foster child
- Newborn dependent of a dependent up to 18 months (applies to medical only)

Dependent Eligibility

Over-age Dependents may be covered by the medical and dental plans through the end of the calendar year in which the child turns age 26.

Medical and dental coverage may continue to the end of the calendar year in which the dependent reaches the age of 30, if the dependent is:

- Unmarried with no dependents; AND
- A Florida resident, or full-time or part-time student; AND
- Otherwise, uninsured; AND
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is handicapped.

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if the dependent is:

- Physically or mentally disabled and incapable of self-sustaining employment by reason of mental disability or physical handicap; AND
- Coverage began prior to the age of 19; AND
- Dependent has been continuously insured.

Proof of disability will be required upon request. Please contact Human Resources if further clarification regarding group insurance eligibility is required.

Taxable Dependents

Employees covering adult children under their medical insurance may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, imputed income for the value of the applicable adult child's coverage for the coverage period must be reported on the employee's W-2. Imputed income is the dollar value of insurance coverage attributable to covering the adult child. There is no imputed income if an adult child is eligible to be claimed as a dependent for federal income tax purposes on the employee's tax return. Check with Human Resources for further details if you are covering an adult child who will turn 27 any time in the upcoming calendar year or for more information.

Domestic Partner

Domestic Partners may be eligible to participate in the City's group medical insurance plans and will be required to complete a Declaration of Domestic Partnership that **must be completed in the Human Resources Department**. The IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to domestic partner coverage. Employees insuring domestic partners and/or child dependents of a domestic partner are required to pay "imputed income tax" on premium deductions and should consult their tax expert. **The establishment of a Domestic Partnership is not a Qualifying Event under Section 125 of the Internal Revenue Code.** Please contact Human Resources for more information.

Spousal/Domestic Partner Surcharge

If a City employee carries his/her spouse or domestic partner on their medical coverage and the spouse/domestic partner is employed with access to insurance coverage through their employer AND declines that coverage, the City employee will be charged $23.08 per biweekly pay period, in order to carry that spouse/domestic partner on the City's coverage as Primary. If your spouse/domestic partner is covered by Medicare as primary, this surcharge would not apply. A Spousal Surcharge form must be completed and submitted to the Human Resources Department.

The City reserves the right to modify, revoke, suspend, terminate or change the program, in whole or in parts, at any time. This is a Benefits Highlight Summary and not a contract. All benefits are subject to the provisions and exclusions under the master contract.

Qualifying Events and IRS Code Section 125

Premiums for medical, dental, vision insurance and contributions to HSA (Health Savings Account) and FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event. Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, if the event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Qualified Life Events include, but are not limited to:

- You get married or divorced
- You have a child, gain legal custody or adopt a child
- Your spouse and/or other dependent(s) passes away
- An increase or decrease in your work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60-day notification period).

Please note: The forming of a Domestic Partnership, in and of itself, is not considered a qualifying event per IRS Code, Section 125.

HR requires appropriate documentation for each Qualifying Event.

HOW TO ENROLL IN BENEFITS

Employees can manage their Benefit elections within Workday. As a new hire you will receive a task in your Workday Inbox. As a non-new hire, you can initiate a Benefit Change when you have a qualifying life event. Here are some instructions to get you started, don't hesitate to reach out to Benefits in HR for more detailed instructions if needed.

New Hires have 30 days from their first day to enroll in benefits. Current employees have 30 days from the day of the qualifying life event (not from when they start the process) to make changes to their benefits.

Initiating the Change Benefit Event

New Hire Benefit Elections

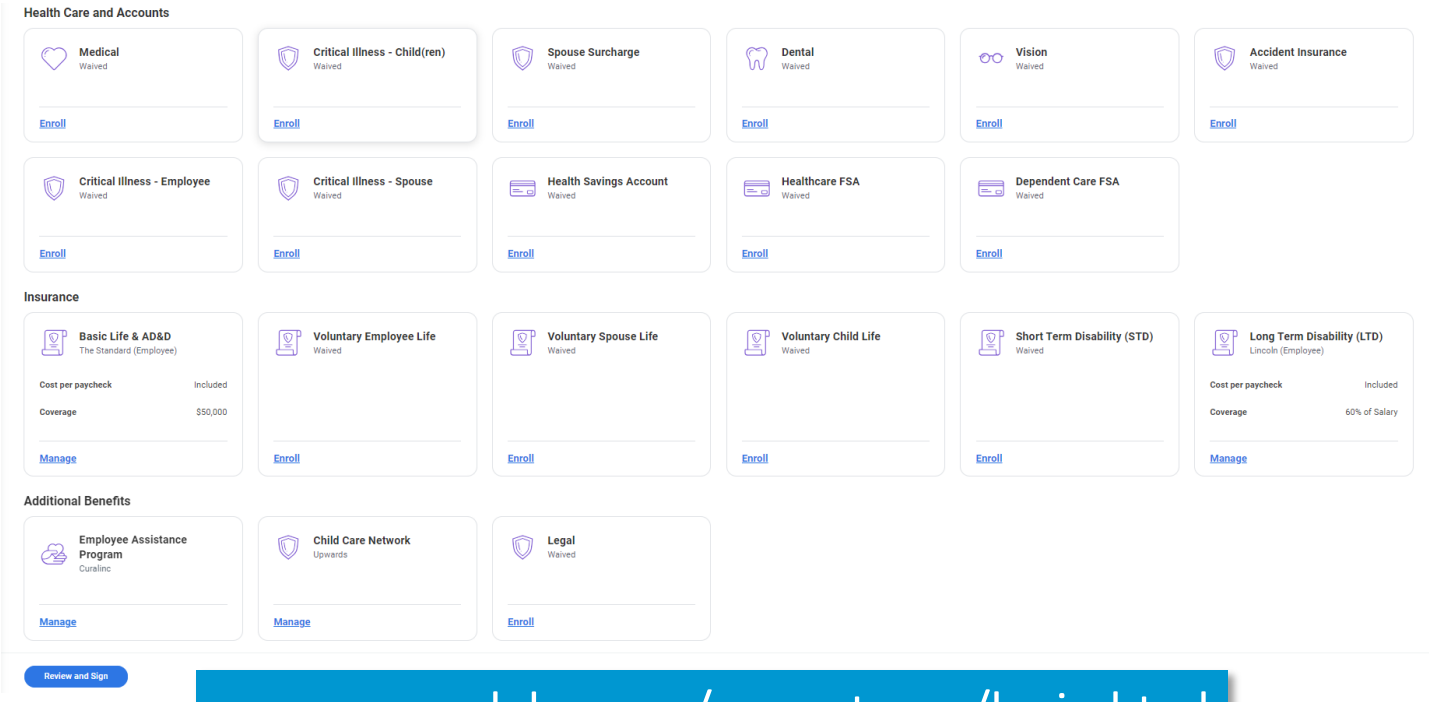
1. Navigate to your Workday My Tasks Inbox
2. Select the item "Benefit Change-New Hire"
3. In the main screen, review the item
4. Click "Let's get Started" to begin the process

Current Employee Qualifying Life Event

1. Navigate to Benefits and Pay App
2. Click Benefits
3. Click Change Benefits
4. Select Qualifying Life Event
   a) Enter the date the event occurred
   b) Upload attachment for proof of event
5. In your My Tasks, you will have the Benefit Change item to get started

Making the Change

Once you start the process, and answer the initial questions, you will be taken to the benefit election home page. Click on each item to see more information and make your selections.



www.myworkday.com/sarasotagov/login.html

HEALTH CENTER

The Sarasota Retiree Health Center (SEHC) is available to retirees and their dependents 6 years and older enrolled in the City's medical insurance plan. It is completely voluntary and private so you can be sure that your medical information will not be shared with your employer. The SEHC can serve you in several ways to help lower your out of pocket costs and improve your health such as short wait times to be seen by the doctor. Spouses and dependents (age 6 and over) are included as long as they are covered on your medical insurance plan and on-site medications are also dispensed at the facility. The SEHC provides the care you and your family need for all non-emergency illnesses.

For those enrolled in Plan 2– HSA, there will be a $5 charge per visit. There is no charge for preventive visits, such as the wellness biometric screening and annual wellness physical. Lab orders and referrals for imaging will also continue to be at no cost.

The clinic provides services such as:

- Primary Care
- Well Woman Visits
- Prescription dispensing
- Labs performed on-site
- ECG's
- Health Risk Assessments
- Health Coaches

To schedule an appointment call **(941) 893-2556** or visit **www.marathon-health.com/mobile/.** The clinic is located at 237 Payne Parkway, Unit 101 Sarasota, Florida 34237

Hours of Operation				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
6am - 4pm (closed Noon - 1pm)	6am - 4pm (closed Noon - 1pm)	6am - 4pm (closed Noon - 1pm)	6am - 4pm (closed Noon - 1pm)	6am - 4pm (closed Noon - 1pm)

Download the Marathon Health Mobile App Today!

The Marathon Health Mobile App empowers you to take charge of your health.
Features include:

- Easy Sign-in and sign up
- Schedule and manage appointments
- Message your care team
- Review your profile information

Scan this QR code with your smartphone's camera to download the Marathon Health app

Message your care team or schedule appointments with ease, and so much more by using the Marathon Health mobile app! Simply scan the below QR code with your phone's camera, click the link and this will bring you directly to where you can download the app! Additionally, you can head to the Apple App Store, or Android's Google Play to manually search and download the App!

The Sarasota Retiree Health Center (SEHC) is an independent company that offers administrative services on behalf of your employer group health plan.

BLUE CROSS BLUE SHIELD MEDICAL INSURANCE

Active Employee Medical Insurance Premiums for 2025

The City provides coverage, administered by Blue Cross Blue Shield, for eligible employees and their dependents. The costs per pay period for coverage are listed in the premium table below. Please refer to the Wellness Incentive page for more information. **For information about your medical plan, please refer to the Summary of Benefits and Coverage (SBC) on our website at Sarasotafl.gov/government/human-resources/benefits**

Medical Plan 1 + Health Reimbursement Account Tier of Coverage	Employee Cost Bi-Weekly	COBRA ** Monthly Cost
Employee Only	$29.00	$827.54
Employee + One	$217.00	$1,650.86
Employee + Family	$260.00	$2,885.84
Dependent Age 26 - 30*	$381.94	$827.54
Medical Plan 2 + Health Savings Account Tier of Coverage***	Employee Cost Bi-Weekly	COBRA** Monthly Cost
Employee Only	$0.00	$724.63
Employee + One	$106.00	$1,436.92
Employee + Family	$194.00	$2,372.81
Dependent Age 26 - 30*	$334.44	$724.63

*Deduction per pay period (in addition to any other deduction) for each dependent age 26 - 30 from the end of the calendar year after the dependent turns 26.
**The 2% administrator fee is charged on the above rates.
***Employees that enroll in medical plan 2, $1000 will be deposited into their HSA account.

2025 CITY OF SARASOTA MEDICAL PLAN 1 - HRA

FL Alt Network (PPO)	In Network	Out of Network**
Calendar Year Deductible (CYD)		
Individual	$750	$1,500
Individual + 1	$1,500	$3,000
3 or More Member Family	$2,250	$4,500
Deductible Type	Embedded	Embedded
Coinsurance* **		
Plan Reimbursement	80%	60%
Member Responsibility	20%	40%
Out-of-Pocket Maximum (Includes Deductible, Coinsurance, & Copays)		
Individual	$2,500	$90,000
Individual + 1	$5,000	$90,000
3 or More Family	$7,500	$90,000
Out of Pocket Type	Embedded	Embedded
Teledoc Visit Copay	$20	N/A
Primary Care Physician*	$20	40% After CYD
Specialists (No Referral Required)	$35	40% After CYD
Acupuncture, Chiropractic, and Massage Therapy Visits (subject to maximums)	$50	$50
Preventative Services*	Covered 100%	40% After CYD
Emergency Room	$250	$250
Urgent Care Facility	$75	$75
Clinical Lab (Blood Work) at QUEST*	$10	40% After CYD
X-Rays at Outpatient Facility*	$10	40% After CYD
Advanced Imaging (MRI, PET, CAT, MRA) Outpatient Facility*	$250 Per Scan	40% After CYD
Inpatient Hospital	20% After CYD	40% After CYD
Outpatient Hospital	20% After CYD	40% After CYD
Mental Health/ Alcohol & Substance Abuse		
Office Visits: Mental Health & Alcohol & Substance Abuse	$20 Copay (PCP), $35 Copay (Spec.)	40% After CYD
Inpatient Hospital: Mental Health / Alcohol & Substance Abuse	20% After CYD / Covered 100%	40% After CYD / Covered 100%
Outpatient Facility: Mental Health / Alcohol & Substance Abuse	20% After CYD / Covered 100%	40% After CYD / Covered 100%
Prescription Drugs		
Deductible	N/A	Not Covered
RX Out of Pocket Maximum:		
Individual / Individual +1 / 3 or More Member Family	$4,100 / $5,700 / $5,700	Not Covered
Tier 1: Generic	$5	Not Covered
Tier 2: Preferred	40% of Cost, Min. $35, Max. $75	Not Covered
Tier 3: Non-Preferred	60% of Cost, Min. $70, Max. $100	Not Covered
Tier 4: Specialty	60% of Cost, Min. $70, Max. $100	Not Covered
Mail-Order Rx (90-day supply)	3x Copay	Not Covered

*These services are provided at no cost when visiting the Sarasota Employee Health Center. SimonMed is available for conditions that are treated and managed within the Health Center and by the Health Center provider.

**Out-of-Network Balance Billing - For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered please to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).

***CYD must be met before any co-insurance applies.

2025 CITY OF SARASOTA MEDICAL PLAN 2 - HSA

IRS rules prohibit those that are Medicare eligible (or those covering a Medicare eligible spouse) from contributing to a Health Savings Account (HSA) and therefore those Medicare eligible will have an HRA instead of an HSA with this plan.

FL Alt Network (PPO)	In Network	Out of Network**
Calendar Year Deductible (CYD)		
Individual	$1,800	$5,000
Individual + 1	$3,300 Embedded Single, $4,000 Max.	$15,000
3 or More Member Family	$3,300 Embedded Single, $4,000 Max.	$15,000
Deductible Type	Embedded	Embedded
Coinsurance* **		
Plan Reimbursement	80%	60%
Member Responsibility	20%	40%
Out-of-Pocket Maximum (Includes Deductible, Coinsurance, & prescriptions)		
Individual	$6,900	$90,000
Individual + 1	$6,900 Embedded Single, $13,800 Max.	$90,000
3 or More Family	$6,900 Embedded Single, $13,800 Max.	$90,000
Out of Pocket Type	Embedded	Embedded
Teledoc Visit Copay	20% After CYD	N/A
Primary Care Physician*	20% After CYD	40% After CYD
Specialists (No Referral Required)	20% After CYD	40% After CYD
Acupuncture, Chiropractic and Massage Therapy Visits (subject to maximums)	20% After In-Network CYD	20% After In-Network CYD
Preventative Services	Covered 100%	40% After CYD
Emergency Room	20% After In-Network CYD	20% After In-Network CYD
Urgent Care Facility	20% After In-Network CYD	20% After IN-Network CYD
Clinical Lab (Blood Work) at Quest*	20% After CYD	40% After CYD
X-Rays at Outpatient Facility*	20% After CYD	40% After CYD
Advanced imaging (MRI, PET, CAT, MRA) Outpatient Facility*	20% After CYD `	40% After CYD
Inpatient Hospital	20% After CYD	40% After CYD
Outpatient Hospital	20% After CYD	40% After CYD
Mental Health/ Alcohol & Substance Abuse		
Office Visits: Mental Health & Alcohol & Substance Abuse	20% After CYD	40% After CYD
Inpatient Hospital: Mental Health / Alcohol & Substance Abuse	20% After CYD / 100% Covered After CYD	40% After CYD / 100% Covered After CYD
Outpatient Facility: Mental Health / Alcohol & Substance Abuse	20% After CYD / 100% Covered After CYD	40% After CYD / 100% Covered After CYD
Prescription Drugs		
Deductible	Combined with Medical	Not Covered
Tier 1: Generic	20% After CYD	Not Covered
Tier 2: Preferred	20% After CYD	Not Covered
Tier 3: Non-Preferred	20% After CYD	Not Covered
Tier 4:Speciality	20% After CYD	Not Covered
Mail-Order RX	20% After CYD	Not covered

*These services are provided for a $5 cost when visiting the Sarasota Employee Health Center. SimonMed is available for conditions that are treated and managed within the Health Center and by the Health Center provider.
**Out-of-Network Balance Billing - For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered please to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).
***CYD must be met before any co-insurance applies.

MAKE THE MOST OF YOUR BENEFITS

Health issues are in the news more than ever. It's a good thing you have access to top-quality care from the largest provider network in the nation.

Please use this guide to make the most of your benefits. We appreciate having you as a member and will do all we can to serve you.

For your health,
Blue Cross and Blue Shield of Florida, Inc.

These topics are included in this guide:

- Using your member ID card
- Finding doctors and cost details on our website
- Discounts on health products and services
- Connecting in ways that work for you — including texts, phone calls, emails, web inquiries and our app
- Tips on the benefits available with your health plan — including telehealth, if applicable

Symbols in this guide:

Log in to your **My Health Toolkit®** account.

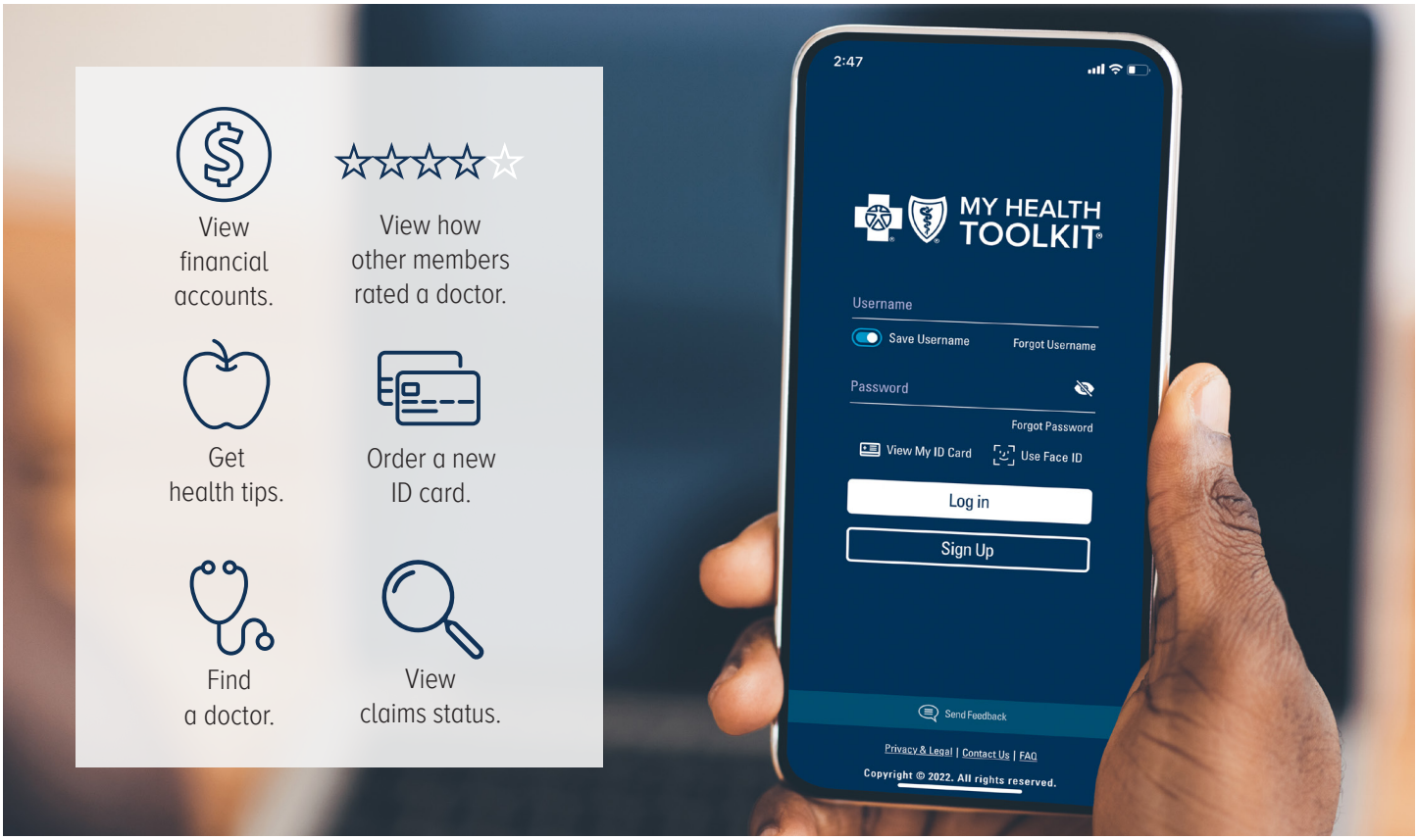
Call the number on the back of your membership ID card to speak to a **customer service advocate**.

TRY THIS SHORTCUT

Get easy access to your benefits information by downloading the My Health Toolkit® mobile app today! It's free on the App Store or Google Play.

Download on the App Store | GET IT ON Google Play

Register quickly through the app using your birth date plus your member ID number or Social Security number. Or just log in if you're already a My Health Toolkit user.



Your account homepage will link you to all of the helpful resources included with your health benefits plan.

Now you have anywhere, anytime access to your benefits information, including claims, discounts and how you prefer to be contacted.

Rather get My Health Toolkit from a desktop or laptop computer?

Go to **www.MyHealthToolkitFL.com** and then:

- Select **Create An Account** within the **Member Login** section.
- Enter your **member ID** (from your ID card).
- Follow the instructions to create your profile, or use the subscriber's Social Security number and your birthdate.

HELPFUL TERMS

Words commonly used in health care

Health care lingo can be confusing. Here are some terms you might need to know.

Claim: A request for payment that you or your health care provider submits to your health insurance company after you receive services.

Copay (or copayment): A set rate you pay for doctor visits, prescriptions and other types of care. For example, you might pay $20 for a doctor visit and $5 for a generic prescription.

Deductible: The set amount you pay for medical services and prescriptions before your coinsurance kicks in fully. For example, you'd meet a $1,000 deductible after your payments for various medical services add up to $1,000.

Coinsurance: The percentage of covered health care costs you pay after you've met your deductible. For example, you might pay 20 percent at that point, and your plan pays 80 percent.

Network: The facilities, providers and suppliers your health plan contracts with to provide health care services. You will typically pay less for services received in network versus out of network.

Out of pocket: Your costs for medical care expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services, plus costs for services that aren't covered.

Subscriber: The person who enrolls in a health plan. There is only one subscriber per health plan. The subscriber can add eligible dependents to a family health plan.

Prior authorization: A decision verifying that a service, prescription drug or type of treatment is medically necessary. Certain services and medications require prior authorization before you receive them, except in an emergency.

Premium: The amount you pay for your health plan's coverage, usually every two weeks or monthly.

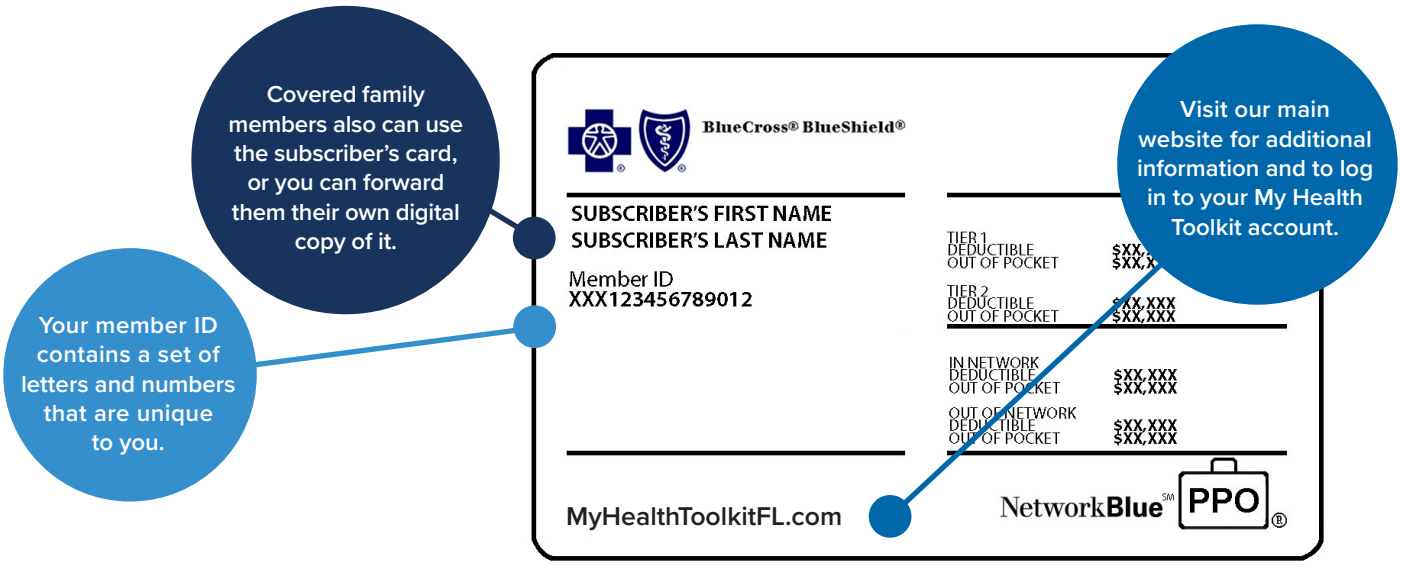
Primary care physician (PCP): The main doctor and primary contact for your health care services.

Specialist: A doctor or health care professional who focuses on a specific area of medicine. For example, orthopedic surgeons, dermatologists and cardiologists are specialists.

Telehealth: Allows a patient to connect with a health care provider with virtual visits through an electronic device such as a smartphone or computer. Licensed telehealth providers offer nonemergency consultations for a variety of conditions and can prescribe medication when appropriate.

WE'VE GOT YOU COVERED WITH YOUR MEMBERSHIP CARD

Your BCBSF membership card contains important information that helps providers apply your benefits correctly. Keep it with you at all times or download a digital ID card to keep on your smartphone. A health care provider usually will ask to see your insurance card at the beginning of your visit.



Convenient option: your digital ID

It's all about convenience! Your digital ID card has the same information as the card you receive in the mail, but you can:

- View the digital ID on a smartphone, tablet or computer.
- Email the card to a spouse, child, doctor's office or pharmacy.
- Print the card from a smartphone, tablet or computer and use the printout just like a plastic card.

Accessing your digital ID

- From a computer or mobile device, log in to My Health Toolkit.
- Follow the prompts to select/view your insurance ID card.

WHEN AN EXPLANATION OF BENEFITS COMES, HERE'S WHAT TO DO WITH IT

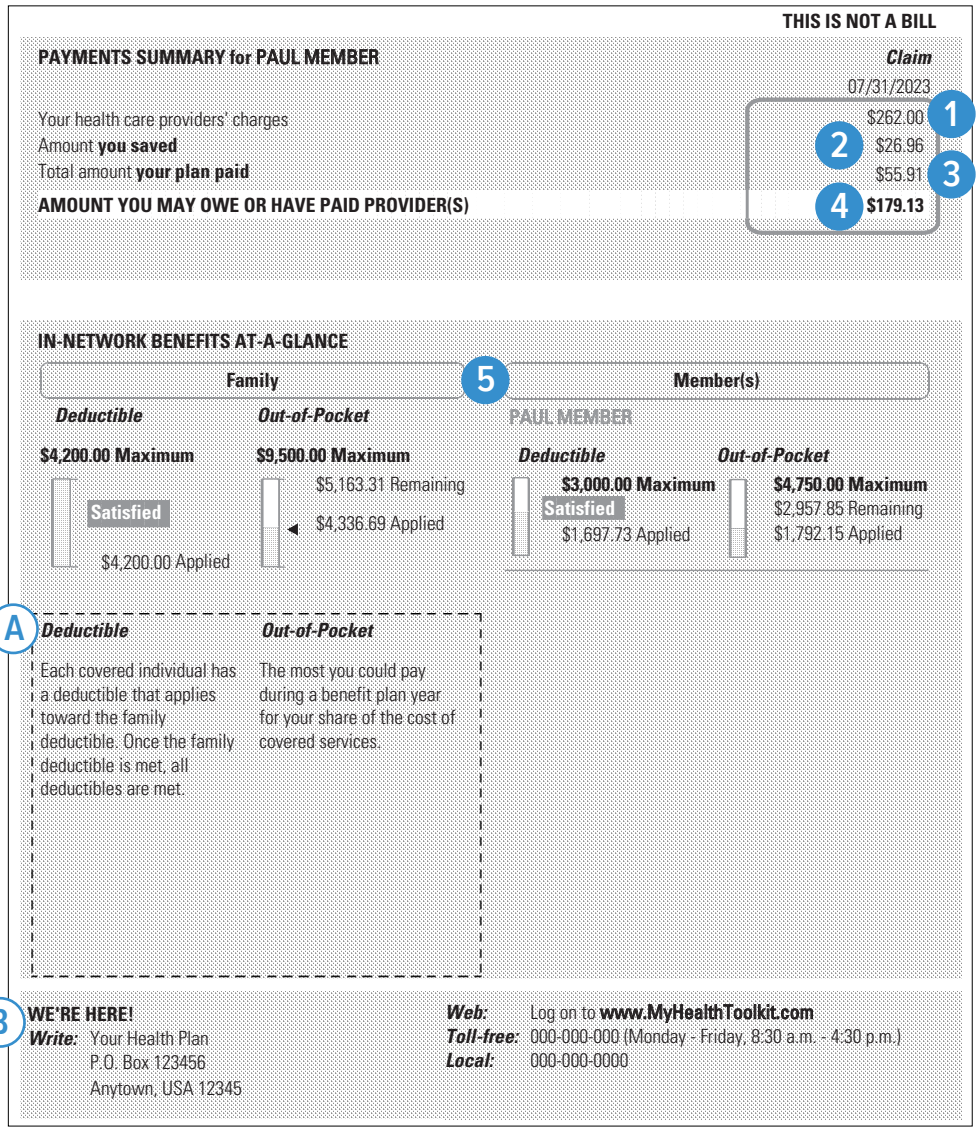
Whenever you use your health insurance, we send you an Explanation of Benefits (EOB). It shows you a breakdown of the services you received, the cost of those services and what you might have to pay your provider. **An EOB is not a bill**.

Your EOB shows you:

1. How much the doctor charged.
2. How much you saved through your health plan.
3. How much your health plan paid.
4. How much you may still owe.
5. How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your in-network benefits.

On page 1, you'll find:

- (A) Helpful definitions.
- (B) How to reach us if you have questions.
- (C) Your member ID number.



THIS IS NOT A BILL

PAYMENTS SUMMARY for PAUL MEMBER — ***Claim*** 07/31/2023

Your health care providers' charges	$262.00 (1)
Amount **you saved**	$26.96 (2)
Total amount **your plan paid**	$55.91 (3)
AMOUNT YOU MAY OWE OR HAVE PAID PROVIDER(S)	**$179.13** (4)

IN-NETWORK BENEFITS AT-A-GLANCE

Family		(5) Member(s)	
Deductible	***Out-of-Pocket***	PAUL MEMBER	
		Deductible	***Out-of-Pocket***
$4,200.00 Maximum	**$9,500.00 Maximum**	**$3,000.00 Maximum**	**$4,750.00 Maximum**
Satisfied	$5,163.31 Remaining	Satisfied	$2,957.85 Remaining
$4,200.00 Applied	$4,336.69 Applied	$1,697.73 Applied	$1,792.15 Applied

(A)

Deductible

Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.

Out-of-Pocket

The most you could pay during a benefit plan year for your share of the cost of covered services.

(B) **WE'RE HERE!**

Write: Your Health Plan
P.O. Box 123456
Anytown, USA 12345

Web: Log on to **www.MyHealthToolkit.com**
Toll-free: 000-000-000 (Monday - Friday, 8:30 a.m. - 4:30 p.m.)
Local: 000-000-0000

Individual Claim Report

EXPLANATION OF BENEFITS

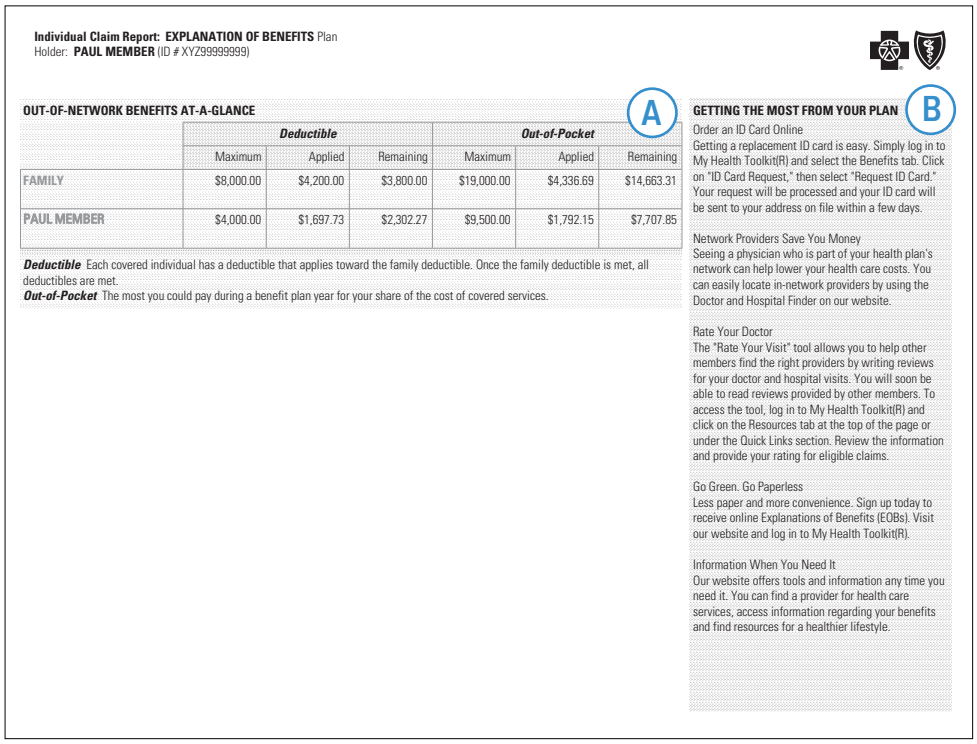
(C) **Plan Holder: PAUL MEMBER**
(ID # XYZ999999999999)
Benefit Plan Year: 01/01/2023 - 01/01/2024
Notice Date: 08/07/2023

On page 2, you'll find:

- **A** How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your out-of-network benefits.
- **B** Tips on using and making the most of your benefits.

On page 3, you'll find:

- **A** Details about your claim, including the claim number and provider.
- **B** When the visit took place and if the provider is in or out of network.
- **C** A breakdown of what your health plan paid and how much you might owe your provider. The amount you might owe does not reflect any amount you may have already paid the provider.
- **D** Additional details about your claim, including why a claim may have been denied.



Individual Claim Report: EXPLANATION OF BENEFITS Plan
Holder: **PAUL MEMBER** (ID # XYZ99999999)

OUT-OF-NETWORK BENEFITS AT-A-GLANCE (A)

	Deductible			*Out-of-Pocket*		
	Maximum	Applied	Remaining	Maximum	Applied	Remaining
FAMILY	$8,000.00	$4,200.00	$3,800.00	$19,000.00	$4,336.69	$14,663.31
PAUL MEMBER	$4,000.00	$1,697.73	$2,302.27	$9,500.00	$1,792.15	$7,707.85

Deductible Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.
Out-of-Pocket The most you could pay during a benefit plan year for your share of the cost of covered services.

GETTING THE MOST FROM YOUR PLAN (B)

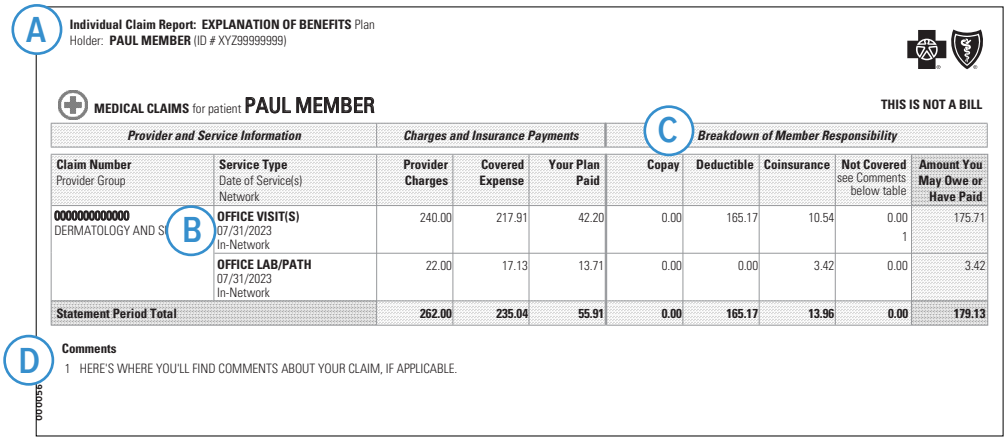
Order an ID Card Online
Getting a replacement ID card is easy. Simply log in to My Health Toolkit(R) and select the Benefits tab. Click on "ID Card Request," then select "Request ID Card." Your request will be processed and your ID card will be sent to your address on file within a few days.

Network Providers Save You Money
Seeing a physician who is part of your health plan's network can help lower your health care costs. You can easily locate in-network providers by using the Doctor and Hospital Finder on our website.

Rate Your Doctor
The "Rate Your Visit" tool allows you to help other members find the right providers by writing reviews for your doctor and hospital visits. You will soon be able to read reviews provided by other members. To access the tool, log in to My Health Toolkit(R) and click on the Resources tab at the top of the page or under the Quick Links section. Review the information and provide your rating for eligible claims.

Go Green. Go Paperless
Less paper and more convenience. Sign up today to receive online Explanations of Benefits (EOBs). Visit our website and log in to My Health Toolkit(R).

Information When You Need It
Our website offers tools and information any time you need it. You can find a provider for health care services, access information regarding your benefits and find resources for a healthier lifestyle.



(A) **Individual Claim Report: EXPLANATION OF BENEFITS** Plan
Holder: **PAUL MEMBER** (ID # XYZ99999999)

MEDICAL CLAIMS for patient **PAUL MEMBER** — **THIS IS NOT A BILL**

Provider and Service Information		*Charges and Insurance Payments*			(C) *Breakdown of Member Responsibility*				
Claim Number Provider Group	**Service Type** Date of Service(s) Network	**Provider Charges**	**Covered Expense**	**Your Plan Paid**	**Copay**	**Deductible**	**Coinsurance**	**Not Covered** see Comments below table	**Amount You May Owe or Have Paid**
0000000000000 DERMATOLOGY AND S (B)	**OFFICE VISIT(S)** 07/31/2023 In-Network	240.00	217.91	42.20	0.00	165.17	10.54	0.00 1	175.71
	OFFICE LAB/PATH 07/31/2023 In-Network	22.00	17.13	13.71	0.00	0.00	3.42	0.00	3.42
Statement Period Total		**262.00**	**235.04**	**55.91**	**0.00**	**165.17**	**13.96**	**0.00**	**179.13**

(D) **Comments**
1 HERE'S WHERE YOU'LL FIND COMMENTS ABOUT YOUR CLAIM, IF APPLICABLE.

SSD000

Every EOB includes important information about how to appeal a denial of your claim. This will help you figure out what to do if you disagree with any of the benefits decisions made on this claim.

Check your EOBs through the **My Health Toolkit®** app or by logging in online. Select **Claims & Authorizations**, **Claims**, and then **Health Claims**.

Choose how you want to receive your EOBs — text, email or mail

You can set your contact preferences when you register for **My Health Toolkit**. Log in and select **Profile**, **My Account** and then **Contact Preferences**.

If you get paper EOBs, an EOB will be mailed to you after a claim has been finalized. If you've opted for online delivery, you'll get an email or text when your EOB is ready to view in **My Health Toolkit**.

MAKE SURE YOU'RE COVERED

Why coordination of benefits is important

Do you have other health insurance?

Coordination of benefits — COB, for short — affects your benefits when you or a family member also is covered under another health insurance plan. COB makes sure the right plan processes your claims first. It prevents overpayments and duplication of services. And that helps keep costs down for everyone.

Examples of other insurance: These may include coverage under a spouse's insurance plan, Medicaid or Medicare.

What you need to do: Be sure we have up-to-date information about your other insurance. That way, we can process your claims correctly and promptly.

- If you receive an Other Health Insurance Questionnaire in the mail, fill it out and return it right away. Even if you do not have coverage with another health plan, we need to know that, too.
- You also can give us this information by logging in to **My Health Toolkit®**. Select **My Plan Benefits**, **Health**, then **Other Health Insurance**.
- Or call the number on the back of your membership card and provide the information to a customer service advocate.

We appreciate your help with this.

Getting benefits after you have declined coverage

Special enrollment rights may apply to you, your spouse or other dependents even after you have declined coverage.

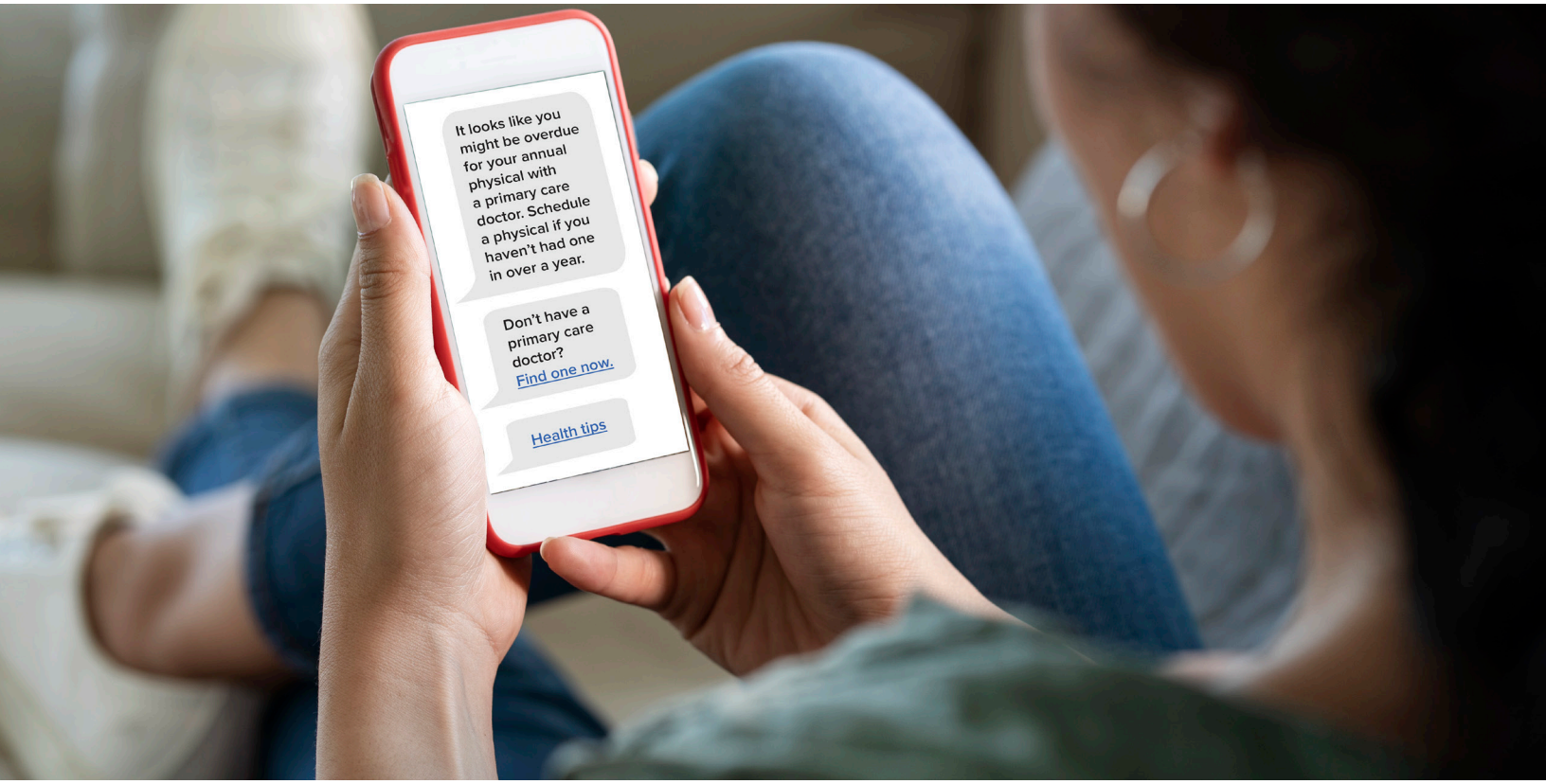
- For example, you might have declined coverage because other health insurance or another group health plan was in effect. Later, you may want to seek coverage with this plan if you or your dependents became ineligible for the other coverage or the employer stopped contributing to the other coverage. You must request our coverage within 30 days after this other coverage ends OR after the employer contribution stops.
- You also may be able to get coverage if you have a new dependent because of marriage, birth, adoption or placement for adoption. Again, you must request enrollment within 30 days of the event.

Please note that you may have been required to provide a written statement when you declined enrollment with us. If you did not provide this written statement, this health plan is not required to grant special enrollment rights to you or your dependents.

For more information, contact your employer's benefit department.

TELL US THE BEST WAY TO REACH YOU

Occasional communications from your health plan help you stay on top of your health, save money and make the most of your benefits. Just let us know which contact channel is most convenient. We'll notify you when it's time for your annual checkup, for example, or if there's an update on a prior authorization request.



Personalized member messages — by text, mail, app notification or email — help us keep in touch by providing useful information and tips.

These could include wellness reminders or news on benefit changes. Please take a minute to update your contact preferences in My Health Toolkit℠ using the tips below.

Log in to My Health Toolkit, and under My Profile, select My Account, then Contact Preferences. You can set your preferred contact for each category — for instance, to get texts from your care manager and emails about your claims.

Keeping your contact information current is the best way to make sure you don't miss any important messages!

WHERE SHOULD YOU GO WHEN YOU NEED CARE?

Your primary care physician should be your first call for routine medical care. But what if your doctor's office is closed? Or it may be an emergency? Or you've been advised to stay home as much as possible?

Here are tips to help you choose the right type of care for various situations.

Teladoc™

A Teladoc virtual visit* is a great option if your doctor's office or urgent care center is closed, you're traveling, or you're not up to driving.

With a virtual visit, you can:

- Use your computer or mobile device.
- See a doctor who can diagnose your symptoms.
- Get a prescription if needed.

Use Teladoc for nonemergency health issues, such as:

- Cold and flu symptoms, including fever, coughing and sore throat.
- Sinus or respiratory infections.
- Urinary tract infections.
- Seasonal allergies.
- Pinkeye.
- Migraine.
- Rashes, insect bites, sunburn or other skin irritations.

Doctor's Office

Your primary care physician, or regular doctor, is the best option for routine medical care. Routine care includes:

- Annual checkups and physicals.
- Health screenings and immunizations.
- Prescription refills.

Your regular doctor can also help with unexpected health issues that can wait a day or so. These might include:

- Sprained muscles.
- Minor cuts and bruises.
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea.
- Sinus or respiratory infections.
- Urinary tract infections.
- Seasonal allergies.
- Pinkeye.
- Migraine.
- Rashes, insect bites, sunburn or other skin irritations.

Emergency Room

Go to the emergency room or call 911 for potentially life-threatening conditions, such as:

- Heavy, uncontrolled bleeding.
- Signs of a heart attack, like chest pain that lasts more than two minutes.
- Signs of a stroke, such as numbness or sudden loss of speech or vision.
- Loss of consciousness or sudden dizziness.
- Major injuries, such as broken bones or head trauma.
- Coughing up or vomiting blood.
- Severe allergic reactions.

*Some services may have age restrictions. Teladoc doesn't guarantee prescriptions, but based on your doctor, dermatologist or psychiatrist's best judgment, they can prescribe medicine or refill prescriptions if medically necessary.

SHOPPING FOR CARE

Find the best health care options just like you check out your choices in cars, hotels or restaurants.

"Know before you go." It's a smart idea before you make any important decision, including finding a new doctor or choosing a location for surgery.

Your health plan makes these decisions easier with Shopping for Care. Find it at your health plan's **My Health Toolkit®** website.

- Find health care providers and services within our vast provider network.
- Check out cost information to make sure you're getting the care you need at the best possible price.*
- See reviews from other patients who have rated a provider you're considering.
- Identify the highest-quality providers in your area, with Total Care and Blue Distinction® Specialty Care designations.
- View a detailed map to help you get where you need to go.

After you've registered with My Health Toolkit®:

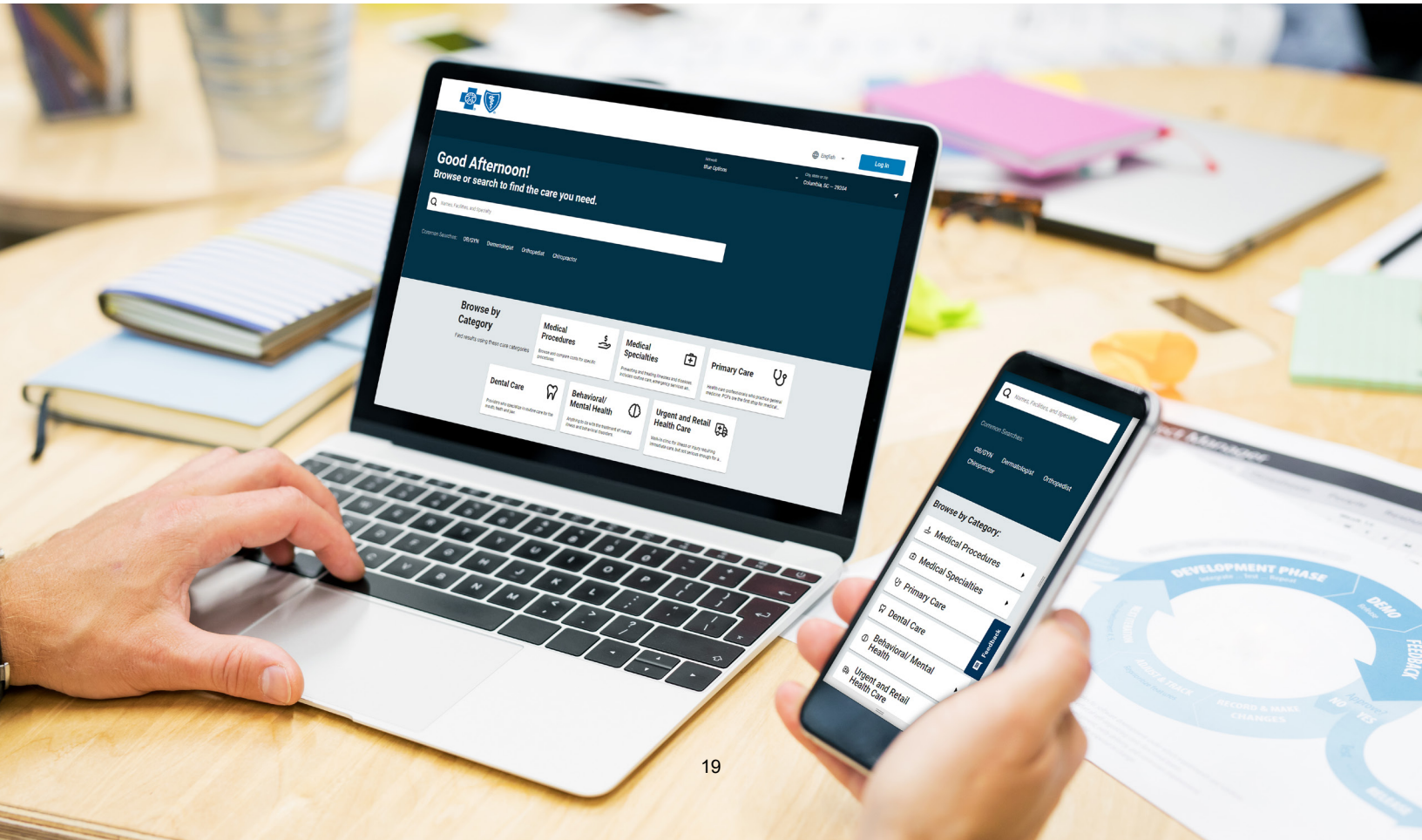
Access Shopping for Care from your computer:

- Visit your health plan's **My Health Toolkit** site.
- Log in to your account, select **Providers and Services**, then **Find Care.**
- We'll walk you through each step!

Or take it with you:

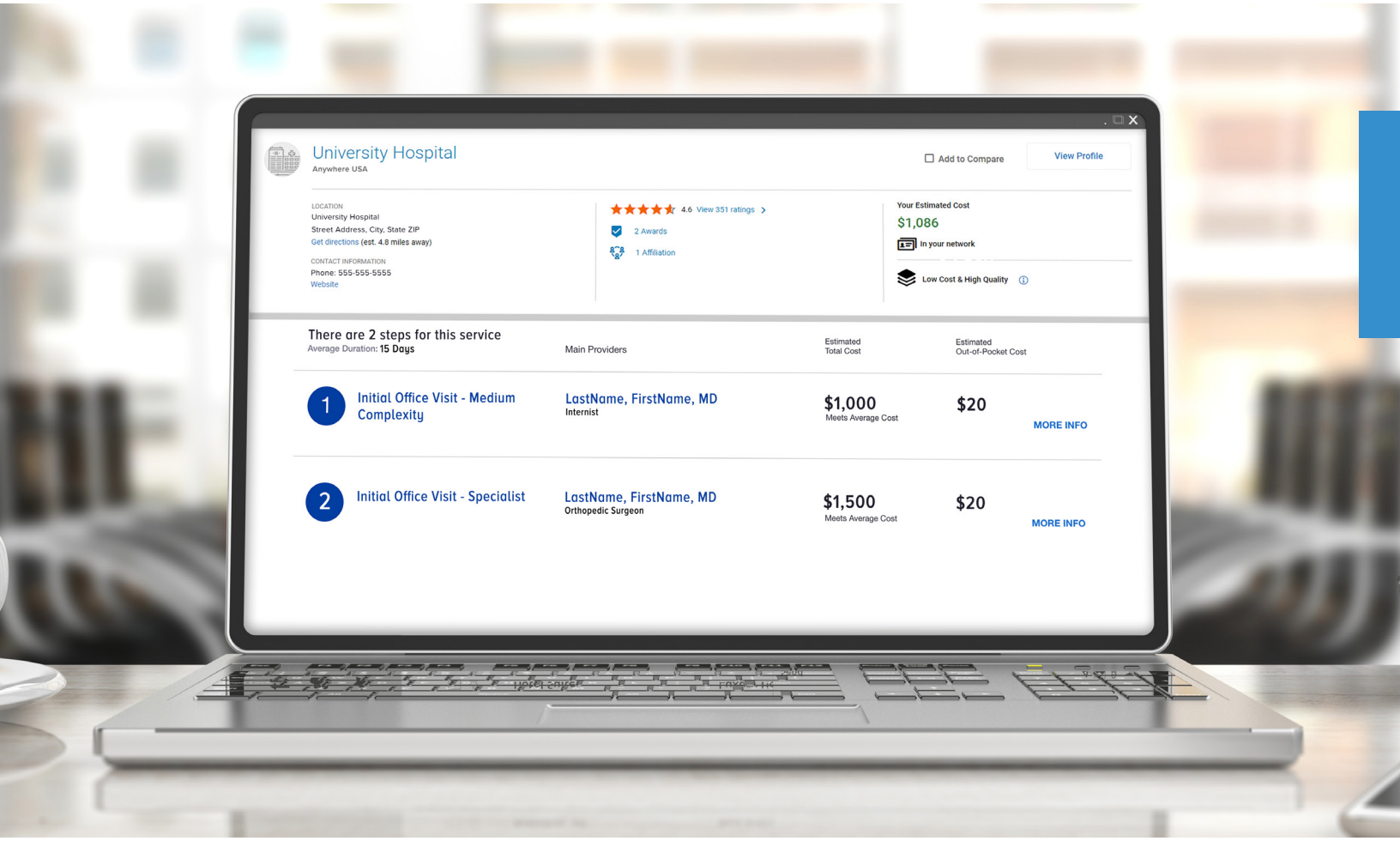
- Log in to the **My Health Toolkit** app from your mobile device.
- Select **Find Care**.

*Cost details might not be included with all plans.



“How much will it cost?”

Estimates help you avoid surprises when the bills come.



Costs for a medical procedure — like an ultrasound, a checkup, X-rays or joint replacement — can vary by hundreds of dollars. Our Shopping for Care feature includes cost estimates to help you find the right care at the right price. (Cost information might not be included for all plans.)

Estimate your out-of-pocket expenses for medical procedures — and compare pricing details that show you the most cost-efficient providers.

- At your health plan’s **My Health Toolkit** website, log in to your **My Health Toolkit** member account.
- Select **Providers and Services**, then **Find Care**.

As you explore the **Find Care** categories further, you’ll see a **Cost Estimates** tab that’s loaded with price information about hundreds of procedures, from mammograms and MRIs to allergy testing, sleep studies, physical therapy and various types of surgery.

TIP: When you get your member ID card, use your ID number to create your My Health Toolkit account. Then you’ll see cost information about copays and other details specific to your health plan.

When Weight Management Is Part of Your Story

MY HEALTH NOVEL℠

The weight management chapter of My Health Novel is designed to match you with helpful resources and tools based on your specific health needs.

It lets you access health management mobile apps at no cost to you.

When you qualify and sign up, you'll get access to health coaching, nutrition guidance, digital tools, group support and more to keep you on track.

How it works:

1. Log in to My Health Toolkit®.
2. Select Wellness & Care Management, Wellness Programs, then My Health Novel.
3. Take a quick, one-minute assessment.
4. You'll receive your recommended programs and resources available to you.

Find support to help you reach and stay at a healthy weight!

MEMBER PERKS

Discounts for you — just for being Blue!

In addition to superior health coverage, your membership provides access to exclusive discounts on a variety of products and services. The member discounts program includes items that generally are not covered byhealth insurance.

Go to our website and select the **Member Discounts** tab. You'll find details on discounts for:

Fitness

- Gym memberships
- Wearable fitness devices
- Activewear
- Magazine subscriptions
- 5K and obstacle course registration
- Home fitness equipment
- Vitamins and nutritional supplements

Personal care

- Allergy relief
- Acupuncture
- Chiropractic services
- Massage therapy
- Hair restoration
- Teeth whitening

Healthy eating

- Weight loss programs
- Cookbooks and recipes
- Online cooking classes

Hearing and vision

- Hearing aids
- Eyewear

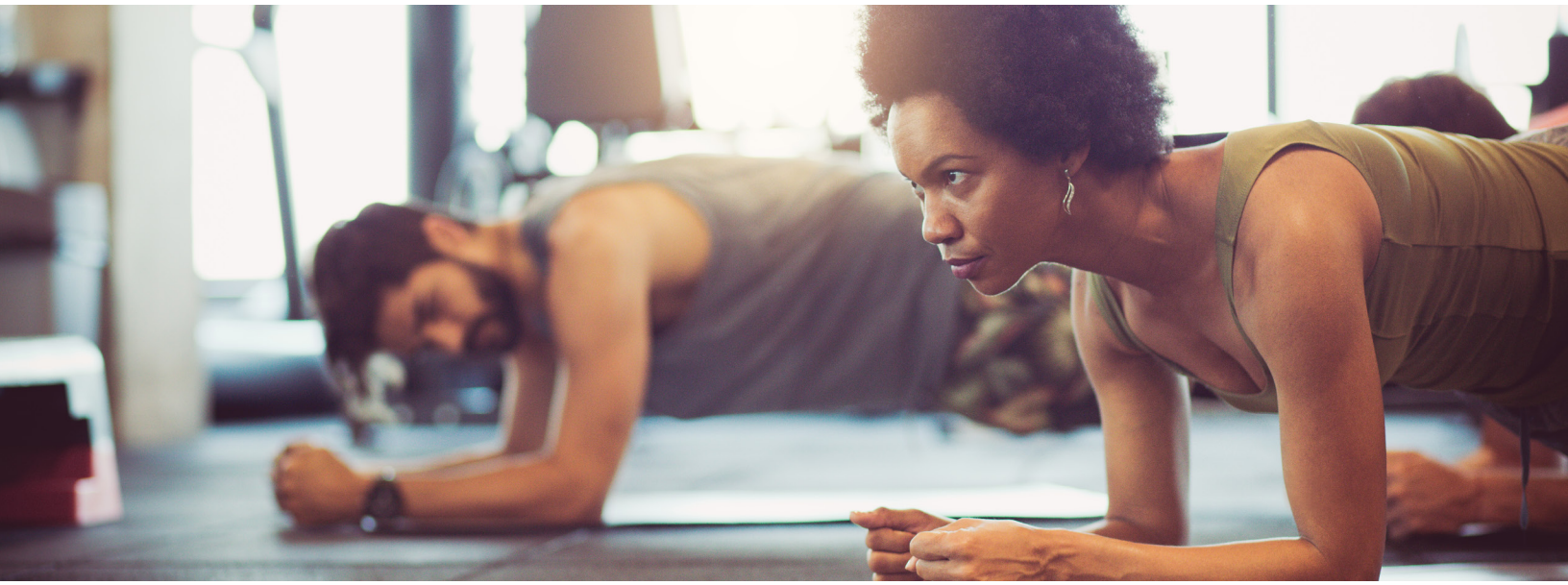
Lifestyle

- Travel clubs
- Vacation packages
- Pet care

HEALTHY LIVING IS JUST A DEAL AWAY

Join Blue365 and start saving today!

Blue365®



Blue365 gives you access to savings across all aspects of your life — including savings on Fitbit devices, low monthly cost gym membership access at over 10K locations, discounts on healthy, organic meal delivery services from Sun Basket and much more!

Register now for free to take advantage of Blue365.
It's an online destination where participating members can find healthy deals and exclusive discounts, all you need is your BlueCross BlueShield of South Carolina member ID card to get started.

Exclusive savings from:

fitbit
GARMIN
TruHearing
SUN BASKET
SKECHERS
fitness your way by Tivity Health
KIND

Get started today at www.Blue365Deals.com/register.

FLORIDA

Blue Cross and Blue Shield of Florida, Inc. is an Independent Licensee of the Blue Cross and Blue Shield Association.

The Blue365 program is brought to you by the Blue Cross Blue Shield Association. The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and/or Blue Shield Companies. Blue365 offers access to savings on health and wellness products and services and other interesting items that Members may purchase from independent vendors, which are not covered benefits under your policies with your local Blue Company, its contracts with Medicare, or any other applicable federal healthcare program. These products and services will be offered to you through the entire benefit year. During the year, the independent vendors may offer additional discounts on these products and services. To find out what is covered under your policies, contact your local Blue Company. The products and services described on the Site are neither offered nor guaranteed under your Blue Company's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding your health insurance products and services may be subject to your Blue Company's grievance process. BCBSA may receive payments from vendors providing products and services on or accessible through the Site. Neither BCBSA nor any Blue Company recommends, endorses, warrants, or guarantees any specific vendor, product or service available under or through the Blue365 Program or Site.

216226-12-2022

CARE COORDINATOR

Call one number to connect with the solutions you need

Navigating your health care can be confusing. How can you find a new doctor? What services are covered under your benefits? Did the hospital bill you correctly? How can you cope with a medical problem?

We can help, by linking you with someone who knows all about your health plan. You'll talk to a customer service advocate or to a Care Coordinator who can guide and support you with solutions for your health care needs

Your Care Team can help you:

Understand your insurance plan
Stay informed about your benefits, make sure you are using them effectively and learn about online tools.

Choose the right care
Get help finding a doctor, choosing a hospital, and comparing costs for treatments or medications.

Navigate the system
Get help communicating with providers, finding care for a particular condition and even scheduling appointments.

Review your bills
Have questions about a bill? Get answers about costs as well as help reconciling any billing errors.

Call 833-644-1299 to speak to a Care Coordinator representative (Mon-Fri. 8am-8pm).

HELP ALONG THE WAY TO BETTER HEALTH

Ready to get on track with your health but not sure where to start? You don't have to figure it out on your own. Your health plan includes free care management programs and resources to help you make positive, meaningful changes at your own pace.

What is care management?

It's a personalized approach that gives you support and lots of options. A care manager can help you reach your health goals, make the most of your benefits and serve as your advocate if you run into obstacles receiving care.

This program is included in your benefits for no additional cost. In some cases, your care manager may help you find ways to lower your medical or pharmacy costs. Connect digitally or by phone!

We offer care management for these conditions:

- Attention-deficit hyperactivity disorder (adults)
- Asthma (adults and children)
- Bipolar disorder
- Heart disease and heart failure
- Chronic obstructive pulmonary disease
- Depression
- Diabetes (adults and children)
- High blood pressure and high cholesterol
- Metabolic health (metabolic syndrome and prediabetes)
- Migraine
- Recovery support for substance use disorder

Case management

If you experience complex or difficult health issues, your nurse care manager will reach out to you to provide support. Things he or she can help with include cancer, transplants, end-stage renal disease, trauma and neonatal intensive care.

Maternity Care

- Personalized digital support during and after your pregnancy
- On-demand access to a maternity nurse

Ready to become a healthier you?

If you qualify for one of our care management programs, we will reach out to you with a phone call, email, text or letter to help you get started. If you have questions, connect with us by phone at **855-838-5897** or through our app, My Health Planner. Just search for **My Health Planner** in the Apple App Store or Google Play and enter access code **ACTNOW** to get started.

QUALITY CARE ... ANYTIME AND ANYWHERE WITH TELADOC®

Why wait for the care you need now? Teladoc gives you 24/7/365 access to a board-certified physician through the convenience of phone or video consults. Teladoc is an independent company that provides telehealth consultation services on behalf of your health plan.

The care you need

Teladoc doctors can treat many of the most common medical conditions, including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infections
- Respiratory infections
- Sinus problems
- Behavioral health and dermatology services may also be covered.

They can also write prescriptions, according to the regulatory guidelines of your state.

When you need it

Teladoc has a national network of doctors ready to answer your call. With an average call-back time of only eight minutes, you can forget about spending hours in the waiting room. Now, you can quickly and easily consult an experienced doctor from the comfort of your home.

It's easy to get started

Register for Teladoc now — don't wait till you are sick!

1. Log in to your **My Health Toolkit®** account.
2. Select **Providers & Services**, and then **Telehealth**.
3. Select **Launch a Visit**.

Want to know more? Please visit your health plan's My Health Toolkit website to learn more about using Teladoc.

PRIOR AUTHORIZATION: STANDARD RADIOLOGY SERVICES

Your health plan requires prior authorization for certain radiology and imaging services in an outpatient setting. If you are in the emergency room or an inpatient setting, you don't have to get prior authorization.

What services require prior authorization?

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiogram (MRA)
- Computed tomography (CT) scans
- Positron emission tomography (PET) scans
- Myocardial perfusion imaging — nuclear cardiology study
- Multigated acquisition scan (MUGA)

What should you do?

Ask your doctor to visit **www.RadMD.com** to request authorization for treatment. If your provider does not receive a prior authorization before you receive services, your health plan might not cover the treatment and you could be held liable for the payment.

What's the status of your prior authorization?

To check the status of your request:

Log in to **My Health Toolkit®**. Select **Claims & Authorizations**, then **Prior Authorizations**. On a mobile device, find **Prior Authorizations** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

The program is designed to:

- Promote patient safety by preventing unnecessary radiation exposure.
- Help you avoid paying unnecessary out-of-pocket expenses.

PRIOR AUTHORIZATION: WHAT YOU NEED TO KNOW

Your health plan requires prior authorization for certain medical tests and treatments. This is an extra step to ensure you receive the appropriate type of care for your condition. If your doctor does not receive authorization before he or she performs the service, it may not be covered by your health insurance.

What types of services require prior authorization?

Generally, prior authorization will be required for these types of services:

- Standard radiology and imaging services, such as magnetic resonance imaging (MRI) and computed tomography (CT) scans
- Radiation therapy for cancer treatment, such as brachytherapy, image-guided radiation and stereotactic therapy
- Spine treatments, such as lumbar decompression or fusion, cervical spine procedures, and spinal epidural injections
- Hips, knees and shoulders treatments, such as arthroplasty and arthroscopy

What should you do?

Most providers will be knowledgeable about services that require prior authorization. You can ask your doctor to visit **www.RadMD.com** to request authorization for treatment.

What's the status of your prior authorization?

To check the status of your request:

Log in to **My Health Toolkit®**. Select **Claims & Authorizations**, then **Prior Authorizations**. On a mobile device, find **Prior Authorizations** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

Or call the number on the back of your membership card to speak to a customer service advocate.

HEALTH SAVINGS ACCOUNTS: HOW DO THEY WORK?

It's not always easy to predict your medical expenses for the year. But setting aside some of your pretax earnings in a health savings account (HSA) can be a good strategy to plan for these expenses. Our administrator for HSAs, AccrueHealth, lets you handle this task in a way that's easier on your budget.

You can set up an HSA if you are opting for a consumer-driven health plan.

Here's how it works:

- Through payments or automatic deposits, you place a certain amount of money in your HSA before taxes are taken out.
- Your employer can help by also making deposits into your account, which earns interest over time.
- Under your consumer-driven health plan, you can use the funds in your HSA for qualified medical expenses — for example, seeing the doctor when you have a sinus infection, or filling prescriptions at the pharmacy.
- There's no "use it or lose it" requirement. Money left in your HSA can roll over to next year — or even come with you if you change jobs. And payments for medical services are tax-free.

Not everyone is eligible for an HSA.

You cannot be:

- Covered by a health plan that is not compatible with HSAs.
- Claimed as another person's income tax dependent.
- Enrolled in Medicare Part A or B, or the Department of Veterans Affairs (VA) health care benefits.
- Eligible for an HSA if your spouse has a health care flexible spending account (unless his or her account has dental and vision reimbursements only).

Qualifying expenses

HSA funds can cover costs for all this and more:

- Copays, deductibles, coinsurance
- Doctor's office visits, exams, lab work, X-rays
- Hospital charges
- Prescription drugs
- Dental exams, X-rays, fillings, crowns, orthodontia
- Vision exams, frames, contact lenses and solution, laser vision correction
- Physical therapy
- Chiropractic care
- Medical supplies
- Over-the-counter medications
- COBRA premiums
- Personal hygiene products

Expenses that are not eligible include these:

- Expenses incurred before opening your HSA
- Cosmetic procedures or surgery
- Dental products for general health

For specific guidance on eligible expenses, please see IRS Publication 502.

Online & mobile access

Link up with AccrueHealth through My Health Toolkit (web or mobile) or through the AccrueHealth mobile app.

Using your HSA

You can use your AccrueHealth debit card to pay a provider for eligible HSA expenses.

If the debit card is not an option, pay out of pocket and request reimbursement online, through the member portal or app, or by mail or fax.

YOUR HRA

A health reimbursement arrangement helps you stretch your health care dollars

Your health insurance plan is a great advantage as you try to stay healthy. But as you've probably noticed, it doesn't cover everything. A health reimbursement arrangement (HRA) can help with out-of-pocket expenses. AccrueHealth administers HRAs on behalf of your health plan.

Your employer deposits funds in your HRA. You can use this money to cover medical expenses for yourself and your family.

Other HRA features:

- It reimburses qualified medical expenses that are not covered by your health plan, such as copays and deductibles.
- Depending on your plan, you can either pay for qualified medical expenses with an AccrueHealth debit card or pay out of pocket and then file a claim for reimbursement from your HRA.
- An HRA can be a stand-alone fund, or it can be integrated with a consumer-driven health plan.
- HRA plan designs vary. Unused funds may or may not roll over from year to year. Also, you might or might not retain access to the HRA if you leave the company. Your human resources department has details on your plan.

How an HRA saves you money:

- It provides funds for a wide range of health services for which you would otherwise pay out of pocket.
- The funds you receive do not count toward your gross income for tax purposes.

Eligible expenses can include:
Ambulance services
Alcoholism and drug treatment
Prescription drugs
Dental care
Laboratory fees
Oxygen
Some types of counseling/therapy
Wheelchairs and crutches
Doctors' fees
Prenatal and postnatal care
Specialists such as psychiatrists and dermatologists

Ineligible expenses include:
Insurance for eyeglasses or contact lenses
Cosmetic surgery and procedures
Electrolysis
Marriage or career counseling
Personal trainers

Helpful details

- Your employer puts money into your HRA and defines which medical expenses are eligible.
- Contributions your employer makes are excluded from your gross income, so are not taxable.
- Save your receipts when you spend HRA dollars. You might need itemized invoices to verify expenses or for reimbursement requests.

For more about federal requirements and what HRAs can cover, see Publication 502 at www.IRS.gov.

YOUR HEALTH CARE FSA

Flexible solutions to enhance your health, save you money

Regular checkups, generic medications, comparing costs … they're all good ways to make the most of your health care dollars. Here's another good way: using a medical flexible spending account (FSA).

Setting up an FSA is easy through AccrueHealth, our administrator for these accounts. It lets you set aside money for health-related expenses your insurance plan does not cover — like an extra pair of eyeglasses, LASIK surgery, and copayments for medical or dental services. And you save money by designating pretax earnings for your FSA.

Here are the basics:

- You set up your payroll deduction for an FSA during open enrollment. These accounts are not for members who choose a consumer-driven health plan.
- You can designate a maximum of $3,200 of your pretax earnings for your FSA. The full amount will be available to you at the beginning of your benefit year, and you will see pretax payroll deductions each pay period.

How does an FSA save you money?

There are no payroll or federal income taxes on the money you shift into your FSA. You've lowered your total taxable income — and you can use the money you save to enhance your health.

Online and mobile access

Link up with AccrueHealth through My Health Toolkit® (web or mobile) or through the AccrueHealth mobile app. You can view your FSA balance, submit claims, store receipts and much more.

More about FSAs

FSA-eligible expenses include these:
Medical, vision and dental copays and deductibles
Vision, hearing and physical exams
Prescription drugs
Orthodontics
Acupuncture treatments
Experimental medical therapies
Ambulance services
Alcoholism treatment
LASIK surgery
Wheelchairs
Over-the-counter medications

Ineligible expenses include these:
Health spa visits
Fitness center dues
Cosmetic surgery
Hair removal and hair transplants
Teeth whitening
Medicines from other countries

FSA tips:

- You may change the payroll election amount only if you experience a major life change, such as these:
  - Marriage, divorce or separation
  - Death of a spouse or dependent child
  - Change in spouse's employment status
  - Birth, adoption or legal guardianship of a child
- For more on federal requirements and what can be covered by FSA funds, see Publication 502 at **www.IRS.gov**.
- For more on your employer's FSA program, contact your human resources department.

Important: There's a "use it or lose it" IRS rule for FSAs. If you don't submit qualifying expenses to use up your balance by the end of the plan year, you lose the funds that are left.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A smarter way to save for dependent care

Would you like to save money on your out-of-pocket dependent care costs – before taxes? A dependent care flexible spending account (FSA) allows you to do just that. Setting up your FSA is easy through AccrueHealth, our administrator for these accounts.

FSA basics

An FSA allows you to set aside pretax funds by having a specified amount deducted from your paycheck each pay period. Because you will be using pretax money to fund your FSA, this will reduce your taxes.

Online and mobile access: Link up with AccrueHealth through My Health Toolkit® (web or mobile) or through the AccrueHealth mobile app. You can view your FSA balance, submit claims, store receipts and much more.

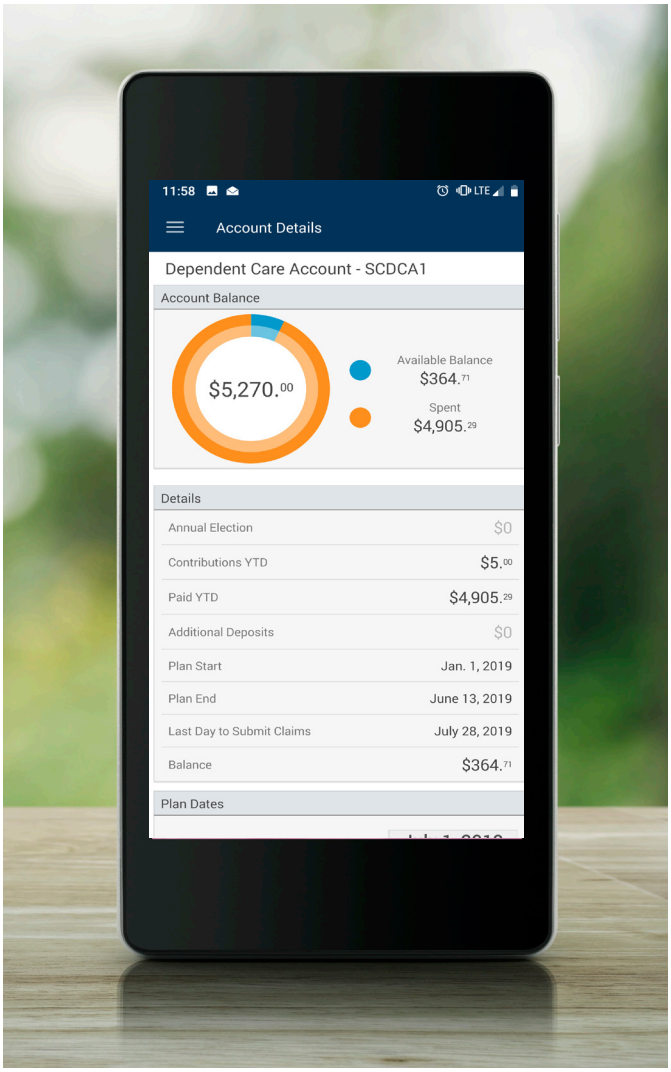
How much to contribute

If you are single, or married and filing a joint tax return, you can put up to $5,000 a year in your dependent care FSA. You may change the designated amount of pretax earnings deposited into your FSA only at the beginning of each plan year or when there is a change in employment or family status.

Examples of family and employment status changes include these:

- Marriage
- Divorce
- Birth of a child
- Adoption of a child
- Death of a spouse or child
- Loss or gain of employment

There's a "use it or lose it" IRS rule for FSAs. If you don't submit qualifying expenses to use up your balance by the end of the plan year, you lose the funds that are left.



Qualifying expenses

To participate in a dependent care FSA if you are married, you and your spouse both must be employed or your spouse must be disabled or a full-time student.

Qualifying dependents include:

- Children under 13 years old who qualify as your dependents for income tax purposes.
- Mentally or physically disabled dependents, including children 13 years old and over, or older people who qualify as dependents for income tax purposes.

The dependent care FSA may be used to pay for dependent care costs such as:

- In- and out-of-home day care.
- Preschool day care.
- Before- and after-school care.
- Summer camp costs, except for overnight camps.

A dependent care FSA may not be used to pay for medical expenses.

For a complete listing of qualifying and nonqualifying expenses, visit the IRS website at **www.irs.gov**. You can also get information from your human resources department or by phone at **800-300-5248**.

Using your dependent care FSA

To use your dependent care FSA you will use your personal funds to pay a provider for eligible dependent care expenses and then submit a claim for reimbursement. You can request reimbursement line, through the member portal or app, or by mail or fax.

PERSONAL SPENDING ACCOUNTS

Link up with AccrueHealth through your My Health Toolkit® account at **www.MyHealthToolkitFL.com**. You can view your account balance, submit claims, store receipts and much more.

Health Reimbursement Account (Plan 1 — HRA only)

An HRA allows you and your dependents to receive reimbursements for qualified out-of-pocket health expenses. Your employer deposits a set amount of money into a tax-free account, which you can use to pay for medical expenses. In addition to the HRA, your employer offers a traditional health plan to cover other medical bills. For a complete list of eligible and ineligible HRA expenses, visit the Internal Revenue Service website at **www.irs.gov*** and view Publication 502.

Health Savings Account (Plan 2 — HSA only)

An HSA is a special savings account that allows you to set aside pretax or after-tax funds for future medical and retirement expenses. You can invest these funds in your choice of stocks or mutual funds or manage the HSA like a traditional savings account. A qualified bank, financial institution or trustee can administer your HSA. You can use your HSA funds to pay your first medical expenses, including office visits, prescriptions and other health care costs. The amount you spend from the HSA for covered medical expenses counts toward your health plan deductible. Once you meet the deductible, the health plan coverage kicks in, and you are only responsible for coinsurance payments.

The 2025 HSA contribution limit is $4,300. Catch-up contribution for those age 55 and over is $1,000.

Flexible Spending Account (Plan 1 — HRA only)

FSAs are designed to help you save money by paying for qualified medical or dependent care expenses on a tax-free basis. An FSA lets you set aside pretax funds from each paycheck. Those funds must be used to pay for qualified expenses incurred during the benefits period. For a complete list of eligible and ineligible FSA expenses, visit the Internal Revenue Service website at **www.irs.gov*** and view Publication 502. *The 2024 FSA contribution limit is $3,200.Please refer to your benefits team for the 2025 FSA contribution limit.*

Dependent Care FSA (Plan 1 — HRA and Plan 2 — HSA)

This type of flexible spending account allows you to use the pretax funds in your account to cover nonmedical costs for a dependent who is under age 13, mentally or physically disabled, or elderly. Examples of these costs include day care, after-school care and summer camps. **No debit card. Must submit receipts.** Your Human Resources department can provide details. The 2025 FSA contribution limit is $5,000.

*These links lead to a third-party website. The Internal Revenue Service is solely responsible for the contents and privacy policy on its site.

Note: The FSA limit amounts may have been updated after this guide was published. Please refer to your benefits team for the most up-to-date FSA limits.

RXBENEFITS PRESCRIPTION PROGRAM

The City's prescription drug program is administered by RxBenefits. RxBenefits is available for eligible employees and their dependents enrolled in the Blue Cross Blue Shield medical program. The costs per pay period are included with the medical rates. For information about your prescription drug program, please call **(800) 334-8134** or visit their website at **optimize.rxbenefits.com/** refer to the Benefit Summary on our website at **Sarasotafl.gov/government/human-resources/benefits**

Member Services for Member Support

RxBenefits' experienced, high-performing call center team delivers a superior level of service

Availability

Member Services is available from 8:00 AM to 9:00 PM ET on Monday – Friday. Member Services can assist you with questions or concerns regarding your pharmacy benefits such as:

- Benefit Details
- Claims Status
- Pharmacy Network
- Coverage Determination/Inquiries
- Mail and Specialty Scripts
- Pharmacy Information
- Clinical Programs

Member Services can be reach at by calling (800) 334-8134 or emailing CustomerCare@rxbenefits.com.
Call center hours 8AM-9 PM Monday-Friday

Paper Claims

Submit prescription receipts along with your specific PBM's claim form to be processed for direct reimbursement. Claims should be mailed to the address listed on your ID card or fax them to RxBenefits at **(205) 449-5225**.

RxBenefits is an independent company that offers administrative services on behalf of your employer group health plan.

RXBENEFITS PRESCRIPTION PROGRAM

Access at your fingertips!

My RxBenefits

By registering for My RxBenefits you'll gain robust information related to your pharmacy benefits whenever is convenient for you, 24 hours a day, 7 days a week. Registering for My RxBenefits will allow you to:

- Chat with a live agent Monday-Friday 10AM-7PM
- Access real time prior authorization status, including explanations of determinations.
- View, download, and email copies of ID cards
- View 18 months of pharmacy claims (including claims for eligible dependents
- Access your account across multiple devices
- Manage your communication preferences
- View pharmacy benefits coverage information

**** Please see QR code on the following page to sign up for the portal****

CVS Caremark App

Now you can manage your prescription benefits anytime, anywhere. Download the CVS Caremark app for on-the-go access with these helpful tools and resources:

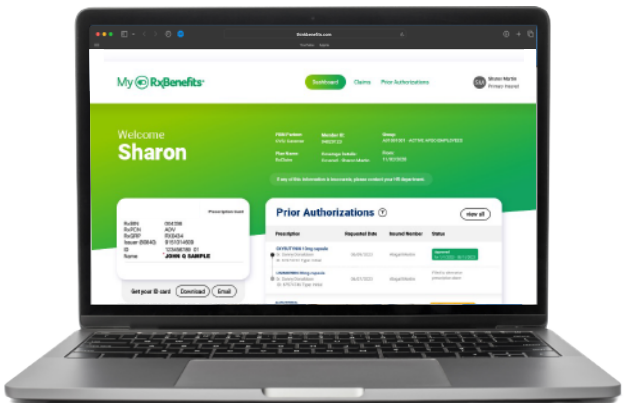
- **Easy Refills**—Scan the barcode on your Rx label to refill available prescriptions.
- **View ID Card**—No need to carry your benefit ID card. With the app, you always have it on hand.
- **Fill New Prescriptions**—Take a photo of the front and back of your new paper prescription and CVS Caremark Mail Service Pharmacy will take it from there.
- **Pharmacy Locator**—Find in-network retail pharmacies near you.
- **Manage Your Profile**—Set your notifications, update shipping and billing information, and more.

My RxBenefits®

Online Access to Your Pharmacy Benefits

By registering for My RxBenefits, **you'll gain access to robust information** related to your pharmacy benefits.

Access your information when it's convenient for you, **24 hours a day, 7 days a week.**



My RxBenefits will allow you to:

- Chat with a live agent Monday - Friday, 9 a.m. to 6 p.m. CT
- Access real-time prior authorization status, including explanations of determinations, and view 18 months of prior authorization activity
- View, download and email copies of ID cards
- View 18 months of pharmacy claims (including claims for eligible dependents)
- Access your account across multiple devices, including computers, tablets, and phones
- Manage your communication preferences
- View pharmacy benefits coverage information

Sign up for the portal at:
https://member.rxbenefits.com

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MyRxBenefits screen designs are not final and are subject to change.

WELLNESS INCENTIVE PROGRAM

The City of Sarasota is committed to wellness and health and continues to adopt plans to encourage healthy behaviors. The City's benefit program includes incentives for eligible employees who complete the biometric screenings and are enrolled in the City Blue Cross Blue Shield Medical Plans.

Wellness Results: How it works

This program is completely voluntary. If you choose to participate, you will need to go to your Primary Care Physician or make an appointment at the Health Center for blood work. At the health center, you can call or go online to schedule an appointment for a fingerstick and visit with the provider to review results. You can also go to your own doctor for completion.

Measurement	Wellness Targets
Weight Measurement A. Waist Circumference ***OR*** B. Body Mass Index	Men - 40" or less / Women - 35" or less BMI - 25 or Less
Tobacco Use	No Use Detected
Blood Sugar	Less than 100 mg/dl
Triglycerides	150 mg/dl or less
Blood Pressure	Systolic - 130 or less / Diastolic - 85 or less
Total Cholesterol	200 mg/dl or less ***OR*** Cholesterol/HDL ratio of 4 or less

The wellness incentive is a pass/fail based on completion of the biometric screenings. Participation is rewarded in the increments below:

Coverage Tier	Amount deposited into HRA or HSA*
Single	$200
Plus One	$500
Family	$700

New City Team Member may participate in the Wellness Incentive Program. Blood work and physician's appointment must be completed by the end of the first month your coverage becomes effective. Total incentive dollars earned will be prorated for the portion of the year that coverage is in effect.

It is the **participant's responsibility** to upload the form into Workday before the deadline.

- Current employees' deadline to upload the form into Workday is October 27th, 2025.
- New City team member must upload the form into Workday within the first 30 days of insurance becoming effective to participate.

METLIFE DENTAL INSURANCE

The City offers dental insurance administered by MetLife. The cost per pay period is listed in the premium table below. A brief description of the Dental PPO Plan is below and a summary of the plan's schedule of benefits is on the following page. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary, contact MetLife at **(800) 942-0854** or visit MetLife's website at **www.metlife.com/mybenefits**

Base Plan 1 Dental PPO Premiums

	Employee Cost Bi-Weekly	COBRA** Monthly Cost
Employee Only	$2.35	$35.00
Employee + One	$4.71	$65.00
Employee + Family	$7.06	$95.00
Dependent Age 26 - 30*	$16.15	$35.00

Buy Up Plan 2 Dental PPO Premiums

	Employee Cost Bi-Weekly	COBRA ** Monthly Cost
Employee Only	$4.95	$42.14
Employee + One	$9.22	$78.26
Employee + Family	$13.46	$114.38
Dependent Age 26 - 30*	$19.45	$42.14

*Deduction per pay period (in addition to any other deduction) for each dependent age 26 - 30 from the end of the calendar year after the dependent turns 26.
**The 2% administrator fee will be charged on the above rates.

Please note the following:

- Each member may receive up to 2 cleanings per year, when utilizing an in-network provider, which must be scheduled 6 months apart.
- Teeth missing prior to coverage under the plan are not covered.
- Waiting periods and age limitations may apply to some services.
- For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of your dental provider. This will assist you with determining your approximate out-of-pocket costs should you have the dental work performed.

Search "MetLife" at iTunes App Store or Google Play to download the MetLife US Mobile App, or scan the QR codes. Search our network of thousands of dentists and specialists to find a provider near you.

Google Play

iPhone App Store

MetLife is an independent company that offers administrative services on behalf of your employer group health plan.

METLIFE DENTAL INSURANCE

Network	PDP Plus			
	Base PPO Plan 1		Buy Up PPO Plan 2	
Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Calendar Year Maximum Per Member	$1,500		**$3,000**	
Calendar Year Deductible (CYD) Per Member	$50		$50	
Calendar Year Deductible (CYD) Per Family	$150		$150	
Waived for Class 1 Services?	Yes		Yes	
CLASS 1: DIAGNOSTIC & PREVENTIVE	**In Network**	**Out of Network***	**In Network**	**Out of Network***
Routine Oral Exam (2 Per Year)	Plan Pays: 80% Deductible Waived*		Plan Pays: 80% Deductible Waived*	
Routine Cleanings (2 Per Year)				
Bitewing X-rays (2 Per Year)				
Panoramic X-rays (1 Per 3 Years)				
Full Mouth X-Rays (1 Per 3 Years)				
Fluoride Treatments (Annually to Age 19)				
Sealants (Every 3 Years to Age 14)				
Space Maintainers (Non-Orthodontic Treatment)				
CLASS 2: BASIC RESTORATIVE				
Fillings (Amalgam & Composite)	Plan Pays: 80% After CYD*		Plan Pays: 80% After CYD*	
Routine Extractions				
Root Canal Therapy				
Periodontal Scaling (Entire Mouth)				
Oral Surgery				
General Anesthesia				
CLASS 3: MAJOR RESTORATIVE**				
Bridges	Plan Pays: 50% After CYD*		Plan Pays: 50% After CYD*	
Crowns				
Dentures				
CLASS 4: ORTHODONTIA**				
Lifetime Maximum	$1,500		$1,500	
Benefit	50% Coinsurance; No Deductible*		50% Coinsurance; No Deductible*	

*Out of Network Balance Billing

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Dental PPO - Participating and Non-Participating Providers section in your Summary Plan Description.

*Late entrant limitation will apply for 12 months on all services

How to Find a Provider

To search for a participating provider, contact MetLife's Customer Service or **(800) 942-0854** or visit MetLife's website **www.metlife.com/mybenefits and type in City of Sarasota** and click on Find a Dentist.

METLIFE does NOT provide ID cards.

MetLife

MetLife is an independent company that offers administrative services on behalf of your employer group health plan.

METLIFE VISION INSURANCE

The City offers vision insurance through MetLife. The employee costs and benefits are provided in the below tables. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary, contact MetLife **(855) 638-3931** or visit MetLife's website at **www.metlife.com/mybenefits and type in City of Sarasota or scan the below QR code to download the app**.

Google Play **iPhone App Store**

Tier of Coverage	Employee Cost Bi-Weekly**
Employee Only	$2.58
Employee + One	$4.91
Employee + Family	$6.40

Network: VSP	MetLife Vision PPO Plan	
Services	**In Network**	**Out of Network**
Eye Exam	$10 Copay	Up to $45 Reimbursement After $10 Copay
Materials	$20 Copay	$20 Copay Applies. Plan Reimbursement Based on the Type of Service
Frequency of Services	**In Network**	**Out of Network**
Examination	12 Months	
Lenses	12 Months	
Frames	12 Months	
Contact Lenses	12 Months	
Lenses	**In Network**	**Out of Network**
Single	Paid In Full After Copay	Up to $30 Reimbursement After Copay
Bifocal		Up to $50 Reimbursement After Copay
Trifocal		Up to $65 Reimbursement After Copay
Frames	**In Network**	**Out of Network**
Basic, Preferred or Non-Preferred	$150 Retail Allowance: 20% discount on balance	Up to $70 Reimbursement After Copay
Contact Lenses*	**In Network**	**Out of Network**
Non-Elective (Medically Necessary)	Covered In full After Copay	Up to $210 Reimbursement After Copay
Elective Lenses	$150 Retail Allowance After Copay	Up to $105 Reimbursement After Copay
Standard Fitting	Covered in full with a maximum copay of $60	Applied to contact lens allowance
Specialty Fitting	Covered in full with a maximum copay of $60	Applied to contact lens allowance

*Contact Lenses are in lieu of spectacle lenses and a frame.
**The 2% COBRA administrator fee will be charged on the above rates.
MetLife does NOT provide ID cards.
For dependent child(ren), coverage will end on their 26th birthday.

MetLife

MetLife is an independent company that offers administrative services on behalf of your employer group health plan.

SUNLIFE ACCIDENT INSURANCE

Accident Insurance

Accident Insurance arranged through Sun Life pays a benefit for over 40 different circumstances to you and/or your covered dependents which can be used for any purpose. Payments an insured person receives depends on the type of injury, such as burns, dislocations, fractures, concussions, eye injuries and lacerations, and accident/injury must take place off the job. Please see the SunLife Benefit Summary for a schedule of benefits and information regarding limitations and exclusions. A $50 Wellness Benefit pays when you and/or your spouse/dependents complete screenings such as mammography, colonoscopy, pap smear, etc.

Important Reminders: *Portability allows you to take the coverage with you even if employment has ended.* For questions, please call Sun Life at **(800) 247-6875.**

Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance's effective date. Unless otherwise specified, benefits are payable only once for each Covered Accident as applicable. The partial list of covered benefits is listed below.

Tier of Coverage	Employee Cost Bi-Weekly
Employee Only	$5.20
Employee + Spouse	$7.73
Employee + Child(ren)	$8.61
Family	$11.14

Life and Dismemberment Losses (shown for employee only*)		
Accidental Death	$25,000	
Loss of one hand, foot, leg, or arm	$7,500	
Loss of sight of one eye or loss of one eye	$7,500	
Dislocations	**Open (surgery)**	**Closed (no surgery)**
Hip	$4,000	$2,000
Knee, ankle, or bones of the foot	$2,000	$1,000
Shoulder	$1,000	$500
Fractures	**Open (surgery)**	**Closed (no surgery)**
Hip or thigh	$4,000	$2,000
Leg	$2,000	$1,000
Hand, foot, ankle, kneecap, or elbow	$650	$325
Toe, finger, or rib	$350	$175
Chip Fractures and other Fractures not reduced by Open or Closed Reduction	25% of the applicable Closed Reduction	
Hospital		
Hospital Admission (once per benefit year)	$1,000	
Ambulance	Air: $1,500 / Ground: $200	
ICU per day (up to 14 days)	$500	

For dependent child(ren), coverage will end on their 26th birthday.

For a complete description on what is covered under Accident Insurance, please refer to the Sun Life booklet or call Sun Life at **(800) 247-6875** or visit their website at **sunlife.com/us**

Sun Life

Sun Life is an independent company that offers services on behalf of your employer group health plan.

SUNLIFE CRITICAL ILLNESS INSURANCE

The City of Sarasota offers critical illness coverage that may be purchased separately on a voluntary basis and premiums paid via payroll deduction for active employees. Voluntary Critical Illness offered through SunLife provides a lump sum benefit payment of certain qualified covered conditions. Benefits are paid directly to you when you need it most. Expenditure for claim proceeds are not limited to medical expenses but can be used at your discretion for things such as childcare, transportation and medical plan copays and deductibles. The benefits are paid even if medical insurance is paying 100% of the cost.

For a complete description on what is covered under Critical Illness Insurance, please refer to the Sun Life booklet or call Sun Life at **(800) 247-6875** or visit their website at **sunlife.com/us**

BENEFITS	
Employee	• You can choose between $5,000 and $30,000 of coverage, in increments of $5,000. No medical questions asked. • Your benefit amount is reduced to 50% at age 70.
Spouse	• If you elect coverage for yourself, you can choose between $2,500 and $15,000 of coverage, in increments of $2,500. No medical questions asked. • Not to exceed 50% of your coverage amount. • The benefit may be reduced when the employee benefit amount is reduced.
Child(ren)	• If you elect coverage for yourself, you can choose $2,500 or $5,000 of coverage. No medical questions asked. • Not to exceed 50% of your coverage amount. • The benefit may be reduced when the employee benefit amount is reduced. • An eligible child is defined as your child from birth to age 26.

Important Reminders: You must be actively at work on the effective date, or your coverage will be delayed until you return to active employment. A pre-existing condition limitation applies. Portability allows you to take the coverage with you even if employment has ended. Please see the SunLife Benefit Summary for a schedule of benefits and information regarding limitations and exclusions.

Sun Life

Sun Life is an independent company that offers services on behalf of your employer group health plan.

SUNLIFE CRITICAL ILLNESS INSURANCE

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is a list of conditions.

COVERED CONDITIONS – *The plan pays 100% of the benefit amount unless stated otherwise.*		
Core Conditions	• Heart Attack* • End-Stage Kidney Disease* • Occupational HIV/Hepatitis B, C, or D • Major Organ Failure*	• Stroke* • Coronary Artery Bypass Graft (Pays 25%)* • Angioplasty (Pays 5%)*
Cancer Conditions	• Invasive Cancer • Non invasive Cancer (Pays 25%) • Skin Cancer (Pays 5%)	
Other Conditions	• Complete Blindness • Severe Burns • Complete Loss of Hearing • Advanced ALS/Lou Gehrig's Disease • Advanced Alzheimer's Disease (Pays 25%)	• Loss of Speech • Advanced Parkinson's Disease (Pays 25%) • Benign Brain Tumor • Coma • Paralysis
Childhood Conditions (applies to dependent children only)	• Down Syndrome • Cerebral Palsy • Cystic Fibrosis • Cleft Lip/Palate	• Type 1 Diabetes Mellitus • Muscular Dystrophy • Complex Congenital Heart Disease • Spina Bifida
Wellness Screening Benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

**Recurrence Benefit available.*
For a complete description on what is covered under Critical Illness Insurance, please refer to the Sun Life booklet or call Sun Life at **(800) 247-6875**.

The below chart can help you locate the bi-weekly pay period premiums for the available coverage amounts. To find your age bracket, use the age you will be on January 1, 2025. The premiums in the age bracket column will show the cost for the coverage amounts in the first column.

Employee Critical Illness - Choice 1 Non-tobacco rates | Age and cost - pay period (bi-weekly) premium

Coverage Amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	1.41	1.50	1.78	2.24	3.07	4.25	5.84	7.94	10.60	13.53	19.27	26.66
$10,000	2.17	2.36	2.91	3.84	5.50	7.85	11.04	15.24	20.54	26.40	37.90	52.67
$15,000	2.94	3.21	4.04	5.43	7.92	11.45	16.23	22.53	30.49	39.28	56.52	78.67
$20,000	3.70	4.07	5.17	7.02	10.34	15.05	21.42	29.82	40.44	52.16	75.14	104.68
$25,000	4.46	4.92	6.30	8.61	12.77	18.65	26.62	37.11	50.38	65.04	93.77	130.69
$30,000	5.22	5.77	7.44	10.20	15.19	22.25	31.80	44.40	60.33	77.91	112.39	156.70

Sun Life

Sun Life is an independent company that offers services on behalf of your employer group health plan.

SUNLIFE CRITICAL ILLNESS INSURANCE

The below chart can help you locate the bi-weekly pay period premiums for the available coverage amounts. To find your age bracket, use the age you will be on January 1, 2025. The premiums in the age bracket column will show the cost for the coverage amounts in the first column. This method will also apply in locating the premium for your spouse's coverage.

Employee Critical Illness - Choice 1 Tobacco rates | Age and cost - pay period (bi-weekly) premium

Coverage Amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	1.44	1.60	2.01	2.75	4.27	6.63	9.93	14.52	20.43	26.96	37.14	46.67
$10,000	2.22	2.54	3.37	4.85	7.90	12.60	19.20	28.39	40.20	53.27	73.62	92.86
$15,000	3.00	3.49	4.74	6.95	11.52	18.58	28.48	42.46	59.98	79.57	110.10	138.70
$20,000	3.79	4.44	6.10	9.05	15.14	24.56	37.76	56.13	79.76	105.88	146.59	184.71
$25,000	4.57	5.38	7.46	11.15	18.77	30.54	47.04	70.00	99.54	132.19	183.07	230.73
$30,000	5.36	6.33	8.82	13.25	22.39	36.51	56.31	83.87	119.31	158.50	219.56	276.74

Spouse Critical Illness - Choice 1 Non-Tobacco rates | Age and cost - pay period (bi-weekly) premium
*Spouse rate is based on the employee's age.

Coverage Amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$2,500	1.03	1.08	1.22	1.45	1.86	2.45	3.25	4.30	5.62	7.09	9.96	13.65
$5,000	1.41	1.50	1.78	2.24	3.07	4.25-	5.84	7.94	10.60	13.53	19.27	26.66
$7,500	1.79	1.93	2.35	3.04	4.29	6.05	8.44	11.59	15.57	19.97	28.59	39.66
$10,000	2.17	2.36	2.91	3.84	5.50	7.85	11.04	15.24	20.54	26.40	37.90	52,67
$12,500	2.55	2.79	3.48	4.63	6.71	9.65	13.63	18.88	25.52	32.84	47.21	65.67
$15,000	2.94	3.21	4.04	5.43	7.92	11.45	16.23	22.53	30.49	39.28	56.52	78.67

Spouse Critical Illness - Choice 1 Tobacco rates | Age and cost - pay period (bi-weekly) premium
*Spouse rate is based on the employee's age.

Coverage Amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$2,500	1.04	1.12	1.33	1.70	2.46	3.64	5.29	7.59	10.54	13.80	18.89	23.66
$5,000	1.44	1.60	2.01	2.75	4.27	6.63	9.93	14.52	20.43	26.96	37.14	46.67
$7,500	1.83	2.07	2.69	3.80	6.09	9.62	14.57	21.45	30.32	40.11	55.38	69.67
$10,000	2.22	2.54	3.37	4.85	7.90	12.60	19.20	28.39	40.20	53.27	73.62	92.68
$12,500	2.61	3.02	4.05	5.90	9.71	15.59	23.84	35.32	50.09	66.42	91.86	115.69
$15,000	3.00	3.49	4.74	6.95	11.52	18.58	28.48	42.26	59.98	79.57	110.10	138.70

Sun Life

Sun Life is an independent company that offers services on behalf of your employer group health plan.

LINCOLN SHORT TERM DISABILITY INSURANCE

The City offers a voluntary short term disability benefit to all eligible employees that work 40 hours per week. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. The short-term disability plan provides a cash benefit when you are out of work for up to 24 weeks due to injury, illness, surgery, or recovery from childbirth. When you are first offered this coverage (and during approved open enrollment periods), you can take advantage of this important coverage with no health examination.

Schedule of Benefits	
Benefits Begin	You must be out of work for 14 days due to an illness / accidental injury before you can collect disability benefits. Benefits begin on the 15th day.
Weekly Benefit Amount	60% of your weekly salary
Maximum Benefit Per Week	$1,000
Benefit Duration	24 Weeks (6 months)

Bi-Weekly Premium*	
Employee Age	Premium Factor
0-29	0.00969
30-39	0.00942
40-44	0.01025
45-49	0.01218
50-54	0.01412
55-59	0.01828
60-64	0.02243
65-69	0.02548
70-99	0.03074

*Premiums for short term disability are post-tax

To Calculate the Cost of Coverage

Your estimated bi-weekly premium is determined by multiplying your weekly salary amount (up to $1,667) by your age-range premium factor. If your weekly salary exceeds $1,667, multiply $1,667 by your premium factor.

Step 1: Enter your weekly salary $ _____

Step 2:Enter the premium factor for your age $ _____

Step 3: Multiply weekly salary (Line 1) by premium factor (Line 2) to get your bi-weekly cost $ _____

Pre-Existing Condition

If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 6 months.

Benefits Offset

Your short-term disability plan will not pay benefits while you receive other income, such as continued income or sick pay from your employer, or Workers' Compensation during your disability. Once this other income stops, your disability benefits may begin— however, the benefits will be reduced by the number of days you received pay from another source.

Benefit Exclusion & Reduction

Like any insurance, this short-term disability insurance policy does have some exclusions. Please review the certificate of coverage for a complete list of benefit exclusions and reductions is included in the policy.

Customer Service

For more information about the benefits provided through this policy, please contact Lincoln at (800) 423-2765 or visit www.lfg.com.

Lincoln Financial Group®

Lincoln Financial Group is an independent company that offers services on behalf of your employer group health plan.

LINCOLN LONG TERM DISABILITY INSURANCE

The City provides an employer paid long term disability benefit to all eligible employees that work 40 hours per week. In the event you become disabled from a non work-related injury or sickness, disability income benefits are provided as a source of income.

Schedule of Benefits	
Benefits Begin	You must be out of work for 180 days due to an illness / accidental injury before you can collect disability benefits. Benefits begin on the 181st day.
Monthly Benefit Amount	60% of your monthly salary
Maximum Benefit Per Month	$10,000
Benefit Duration	Up to Social Security Normal Retirement Age or age 65, whichever is later.

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Customer Service: For more information about the benefits provided through this policy, please contact Lincoln at (800) 423-2765 or visit www.lfg.com.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

Lincoln Financial Group®

Lincoln Financial Group is an independent company that offers services on behalf of your employer group health plan.

ARAG LEGAL INSURANCE

ARAG Legal Insurance Plans covers a wide range of legal needs. Legal coverage is not just for the serious issues. It helps you address common situations like creating wills, transferring property or buying a home.

Ultimate Advisor includes, but not limited to:

Consumer Protection Matters
- Auto Repair
- Buying/Selling a car
- Consumer Fraud
- Consumer Protection for Goods and Services
- Contracts & Financial Disputes
- Insurance Disputes

Criminal Matters
- Juvenile Court Proceedings
- Parental Responsibilities

Debt-Related Matters
- Debt Collection
- Garnishment
- Personal Bankruptcy
- Student Loan Debt Collection

Family Law
- Adoption Proceedings Uncontested & Contested
- Conservatorship Uncontested & Contested
- Divorce Uncontested
- Divorce Contested (up to 30 hours per event)
- Domestic Partnership Agreement
- Funeral Directive
- Gender Identifier Change
- Guardianship Uncontested & Contested
- Hospital Visitation Authorization
- Postnuptial Agreements
- Pet-Related Matters

General Matters
- Credit Records Correction
- Document Preparation
  - Affidavits
  - Bill of Sale
  - Demand Letters
  - HIPAA Authorization
  - Promissory Notes
- Document Review
- Personal Property Disputes

Government Benefits
- Medicare/Medicaid Disputes
- Social Security Disputes
- Veterans Benefits Disputes

Real Estate Matters (Primary & Secondary Residence)
- Deeds and Mortgages
- Foreclosure
- Home Improvement/Contractor Disputes
- Neighbor Disputes
- Property Tax
- Purchase/Sale of House
- Real Estate Disputes

Services for Tenants
- Contracts/Lease Agreements
- Eviction
- Security Deposits
- Tenant Disputes with a Landlord

Tax Matters
- IRS/State/Local Audit Protection
- IRS/State/Local Collection Defense

Traffic Matters
- Drivers License Suspension & Revocation
- Minor Traffic Ticket

Wills and Estate Planning
- Complex Will
- Durable/Financial Power of Attorney
- Estate Administration (Probate) *(Up to 9 hours)*
- Health Care Power of Attorney
- Living Will
- Standard Will
- Trusts –Revocable & Irrevocable

Ultimate Advisor Plus includes all coverages listed above in Ultimate Advisor, and more, including:

- Alimony (up to 8 hours per event)
- Child Custody (up to 8 hours per event)
- Child Support(up to 8 hours per event)
- Child Visitation Rights (up to 8 hours per event)
- Divorce Uncontested
- Divorce Contested (up to 30 hours per event) (was up to 20 hours)
- Supplemental Legal Coverage (up to 4 hours per year)
- Criminal Misdemeanor
- Parents & Grandparents Service enhancements- (NEW for 2025!) these include, document prep and review, Wills, and Power of Attorney, Misc. services (4 hrs covered time for any legal matter).

How does legal insurance work?

1. Call **(800) 247-4184** when you have a legal matter.
2. Customer Care will walk you through your options and help you get connected with network attorneys.
3. Meet with your attorney over the phone or in person to begin resolving your legal issue.

See a complete list of what your plan covers at:
ARAGlegal.com/myinfo Access Code: 11254cos

Plan	Employee Cost Bi-Weekly
Ultimate Advisor	$8.42
Ultimate Advisor Plus	$10.24

The ARAG Legal app makes it easy for members to get legal help on the go.
- Find a network attorney
- Case Assist
- Mobile ID card
- Contact ARAG through the app

Look up "ARAG Legal" in Google Play or the iPhone app store to download.

GET IT ON Google Play | Download on the App Store

ARAG is an independent company that offers services on behalf of your employer group health plan.

STANDARD LIFE INSURANCE

Basic Term Life & Accidental Death & Dismemberment Insurance

The City provides a Basic Life and matching Accidental Death and Dismemberment insurance benefit to all eligible full-time employees working a minimum of 30 hours per week at no cost. The benefit for all full-time active employees is $50,000. Under this plan, your coverage amount reduces 65% at age 65, 50% at age 70 and 35% at age 75.

Always remember to keep your beneficiary forms updated. You may update your beneficiary at any time through Workday.

Voluntary Employee Life Insurance

Eligible employees may elect to purchase additional life insurance on a voluntary basis through Standard Insurance Company. This coverage may be purchased in addition to the Basic Term Life coverage. Voluntary Life insurance offers coverage for yourself, your spouse and/or child(ren) at different benefit levels.

Only For New Hires: There is a 1-time Special Enrollment to purchase voluntary employee life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI) up to the guaranteed issue amount of $250,000. Any amount requested over $250,000, the Evidence of Insurability (EOI) will be required for new hires. For All Other Employees: If an increase on the original amount is requested, then an Evidence of Insurability (EOI) will be required.

Voluntary Life	
Employee Age	Bi-weekly Rates per $10,000
Under 30	$0.28
Age 30 - 34	$0.37
Age 35 - 39	$0.42
Age 40 - 44	$0.55
Age 45 - 49	$0.97
Age 50 - 54	$1.71
Age 55 - 59	$2.82
Age 60 - 64	$3.46
Age 65 - 69	$6.05
Age 70 - 74	$6.18
Age 75 +	$5.15

- Units can be purchased in increments of $10,000 from a minimum of $10,000 to a maximum of $500,000. Up to $250,000 with no Medical Underwriting for new hires.
- Premium calculation: Elected Coverage x Employee Rate (see table) = Bi-weekly Premium
- Premiums are not locked in and increase when age bands are crossed.
- Under this plan, your coverage amount reduces 65% at age 70 and 50% at age 75.

Voluntary Spouse Life Insurance

- An employee must participate in the voluntary plan for his/her spouse to participate.
- Units can be purchased in the amounts of $5,000 or $10,000. Coverage cannot exceed 50% of the employee's voluntary coverage amount.

Voluntary Dependent Life Insurance

- An employee must participate in the voluntary plan for his/her dependent children to participate.
- Coverage in the amount of $2,500 or $5,000 can be purchased for children 0 months to age 25.

Voluntary Spouse/Dependent Life Insurance Premium Cost

- Spouse: Option $5,000 or $10,000 – Bi-weekly Spouse rate is $0.74 or $1.48
- Child: Option $2,500 or $5,000 – Bi-weekly Child rate $0.23 or $0.46

Customer Service: For more information about the benefits provided through this policy, please contact The Standard at **(800) 348-3226** or visit **www.standard.com**

Standard Insurance Company is an independent company that offers services on behalf of your employer group health plan.

Upwards

For employees of City of Sarasota

We're solving family care for good.

Upwards is your personal assistant for finding full-time, licensed, and quality early educators who are affordable and nearby.

We help every family find and afford care for their loved ones.

Match with the best childcare provider based on your exact needs, including weekend, nighttime, and backup care.

We make touring safe and convenient by allowing you to video tour directly from the Upwards app.

All Upwards caregivers are held to the highest quality standards. We offer unlimited transfers to guarantee your happiness!

Upwards is typically 40% less expensive than other childcare alternatives — and offers flexible payment options.

Sign up today!

upwards.com/benefits/cityofsarasota

(941) 841-3611

Upward FREQUENTLY ASKED QUESTIONS

What types of care does Upward provide?

Upward's dedicated care managers provide access to 24/7 placement services and customer support. We quickly connect parents to childcare providers with flexible schedules that include babysitters, nannies, tutors, full-time, part-time, drop-in, weekend, special needs, and overnight care options. If a childcare provider is outside of your budget, our dedicated care managers will contact the provider.

Once I sign up, what's next?

After signing up for your childcare assistance through Upward, you will receive a confirmation email and text with more details. Once you are ready to find care, give us a call or message us in our app and we'll help to complete your childcare profile to start the process! Even if you do not need care immediately, you can sign up at any time, and circle back when you are ready to enroll your child

What does my assistance include?

Your assistance includes access to 24/7 childcare services that include full-time,
part-time, backup, drop-in, and overnight care options, as well as 24/7 support for finding care and managing your experience once you start care. Your employer is also covering drop-in care and can create customized childcares specifically for your organization.

How much does Upward tuition cost?

Our concierge fees to hand-pick childcare to suit your specific needs is covered by your employer, saving you 2-3 months of searching. All Upwards have different unique care philosophies and they are empowered to set their tuition based on age, schedule, and other factors. However, our studies have shown that Upward tuition rates are about 40% more affordable than traditional childcare options on the market.

How do I pay for childcare?

Payments are automatically billed weekly, so you can "set it and forget it" and take one more thing off your plate! You can pay via credit, debit, and ACH

How are Upwards vetted?

All in-network Upward providers are licensed to provide childcare, background checked, CPR and safety certified, experienced childcare experts, and many are experienced teachers. Providers' licenses are checked and verified for quality and safety by Upward daily.

How does Upward help?

Upward's concierge service helps match you with childcare providers that perfectly suit your needs. Once you enroll your child, we automate the provider's billing, so you never have to worry about making payments. If a provider is a little out of your budget, we can reach out and negotiate rates to ensure you're getting what you need at the price you prefer. If you have any questions or last-minute needs, we have a support system ready to help you 24 hours a day, 7 days a week. There is a feature on the Upward app called Moments that allows providers to share photos and videos of your child. Providers love showing off art projects, activities, and impressive work.

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What schedules does Upward support?

Childcare placement services include full-time, part-time, drop-in, weekend, and overnight care options.

How quickly can Upward find care?

Depending on the area and placement, our matchmaking team will usually present you with a few options within the first 2 business days of you contacting us for help.

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Upward is an independent company that offers services on behalf of your employer group health plan.

spot pet insurance

America's Favorite Pet Insurance!

Get Peace Of Mind Today With Our Pet Coverage

*May enroll at any time through the year

Accidents

Spot plans help ensure your pet is covered from head-to-tail for unexpected accidents and injuries.

Illnesses

Spot plans cover exams for qualified illnesses and related treatment, including things like surgeries & medications.

Wellness

Spot's **optional** Preventive Care plans focus on routine care and regular check-ups to help ensure their routine wellbeing.

We Take Care of Our Pack

- Vet Exam Fees
- Behavioral Issues
- Dental Illnesses
- Surgery
- Microchip Implantation
- Unexpected Emergencies
- Hereditary Conditions
- Prescription Medications
- Diagnostics
- X-rays & Tests
- Cancer & Growths
- And Much More...

Flexible Plans For Any Budget

Customize your annual limit, deductible and reimbursement rate to make your pet and wallet happy.

Simple & Easy Claims Process

1. Visit Any Vet in the U.S or Canada
2. Submit Your Claim Online
3. Get Cash Back for Covered Vet Bills!

Unleash More with Spot

Spot Perks

Special discounts on pet products and services from your favorite brands.

24/7 Pet Telehealth Line

Get unlimited 24/7 virtual pet care from vet experts for your pet.

CITY OF SARASOTA

Get Your Special Discount*

spotpet.link/sarasota

*10% employee discount available on all pets. Not available in HI or TN. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms visit spotpetins.com/sample-policy. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by either Independence American Insurance Company (NAIC #26581. A Delaware insurance company located at 11333 N. Scottsdale Rd. Ste. 160. Scottsdale. AZ 85254) or United States Fire Insurance Company (NAIC #21113. Morristown, NJ), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385. 990 Biscayne Blvd Suite 603, Miami, FL 33132. CA License #6000188).

SUPPORTLINC EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is arranged through SupportLinc. You are eligible to talk to a provider confidentially 5 times per issue per year. SupportLinc program features include:

- **In-the-moment support.** A licensed clinician answers 24/7/365 when you call for assistance with work-related pressures, depression, stress, anxiety, grief, relationship problems, substance abuse or other emotional health concerns.
- **Short-term counseling.** You and your immediate household members may also receive up to **five (5)** counseling sessions, in-person or via video.
- **Legal consultation.** Receive a free, 30-minute legal consultation per issue with a local attorney, by phone or in-person.
- **Convenience resources.** Knowledgeable specialists provide referrals that help address a wide range of challenges such as child or elder care, adoption, pet care, home repair, education and housing needs.
- **Financial expertise.** Consultation and planning with an experienced financial professional, providing pressure-free, personalized guidance until your issue is resolved.
- **Web platform.** Your one-stop shop for program support, resources, information and more. Discover on-demand training to boost wellbeing. Find discounted gym memberships, financial calculators, self-assessments and career resources. Visit the Savings Center for a variety of discounts. Or complete a search to explore articles and tip sheets.
- **Mobile app.** Get confidential support and guidance on the go from a licensed counselor via live chat, as well as expert content and resources – all from the convenience of your phone or tablet.
- **Text therapy.** Exchange text messages, voice notes and resources Monday – Friday with a licensed counselor through the Textcoach® mobile and desktop app.
- **Animo.** Strengthen your mental health and overall wellbeing at your own pace using Animo's self-guided content, practical resources and daily inspiration to foster meaningful and lasting behavior change.
- **Virtual Support Connect.** This digital group support platform offers moderated sessions hosted by licensed counselors on topics such as grief, mindfulness, preventing burnout and more.
- **Navigator.** Take the guesswork out of your emotional fitness! Click the Mental Health Navigator icon on the web portal or mobile app, complete a short survey and receive personalized guidance for accessing program support and resources.

Contact SupportLinc at **(888) 881-5462** or visit SupportLinc's website at **supportlinc.com and type in group code: cityofsarasota or scan the QR code to download the app.**

supportlinc EMPLOYEE ASSISTANCE

GET IT ON Google Play

Download on the App Store

SupportLinc is an independent company that offers services on behalf of your employer group health plan.

KEY CONTACTS

Please refer to this list when you need to contact one of your benefits vendors. For general information, contact your Human Resources Department.

Benefit	**Carrier**	**Contact Information**
Human Resources	City of Sarasota	Fitzroy Hibbert Fitzroy.Hibbert@SarasotaFL.gov (941) 263-6338
Medical	BlueCross BlueShield	(833) 644-1299
Health Reimbursement Account, Flexible Spending Account, & Health Savings Account	Accrue Health	844-643-3099
Prescription Drug & Mail Order Program	RxBenefits	(800) 334-8134
Telehealth– Virtual Visits	Teladoc	(866) 789-8155
Employee Health Center	Marathon	(941) 893-2556
Dental	MetLife	(800) 942-0854
Vision	MetLife	(855) 638-3931
Life	The Standard	(800) 348-3226
Critical Illness with Cancer & Accident	SunLife	(800) 247-6875
Short-Term & Long-Term Disability	Lincoln Financial	(800) 423-2765
Employee Assistance Program	SupportLinc	(888) 881-5462
Child Care Program	Upward	(941) 841-3611
Legal Protection Plan	ARAG	(800) 247-4184 Access Code: 11254cos
Pet Insurance	The Spot	(800) 905-1595 Spotpet.link/sarasota
Escalated Medical & Dental Claims Issues	Brown & Brown	Dani Hochmuth dani.hochmuth@bbrown.com (386) 333-6089

NON-DISCRIMINATION STATEMENT AND FOREIGN LANGUAGE ACCESS

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, religion, health status in our health plans, when we enroll members or when we provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice **(TDD 711)**.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing **contact@hcrcompliance.com** or by calling our Compliance area at **800-832-9686** or the U.S. Department of Health and Human Services, Office for Civil Rights at **800-368-1019** or **800-537-7697 (TDD)**.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ąąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

NOTES

NOTES

We're glad to have you as a member of Blue Cross and Blue Shield of Florida, Inc. What did you think of this open enrollment guide? Please take a moment to scan this QR code and give us some feedback.

FLORIDA

Blue Cross and Blue Shield of Florida, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Blue Cross and Blue Shield of Florida, Inc. is an Independent Licensee of the Blue Cross and Blue Shield Association.

OE-FL-7-2022