RETIREE BENEFIT GUIDE

January 1, 2025 – December 31, 2025

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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 retiree 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

The City's benefit plan is January 1st to December 31st

Retiree Eligibility

- Retiree's coverage will be effective the date of retirement.

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)

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.

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 a retiree may not receive a tax advantage on any portion of premium paid related to domestic partner coverage. Retirees 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 retiree 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 retiree will be charged $50.00 per month, 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.

Qualifying Events and IRS Code Section 125

Premiums for medical, dental, and vision insurance 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

Retirees can manage their Benefit elections within Workday. 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.

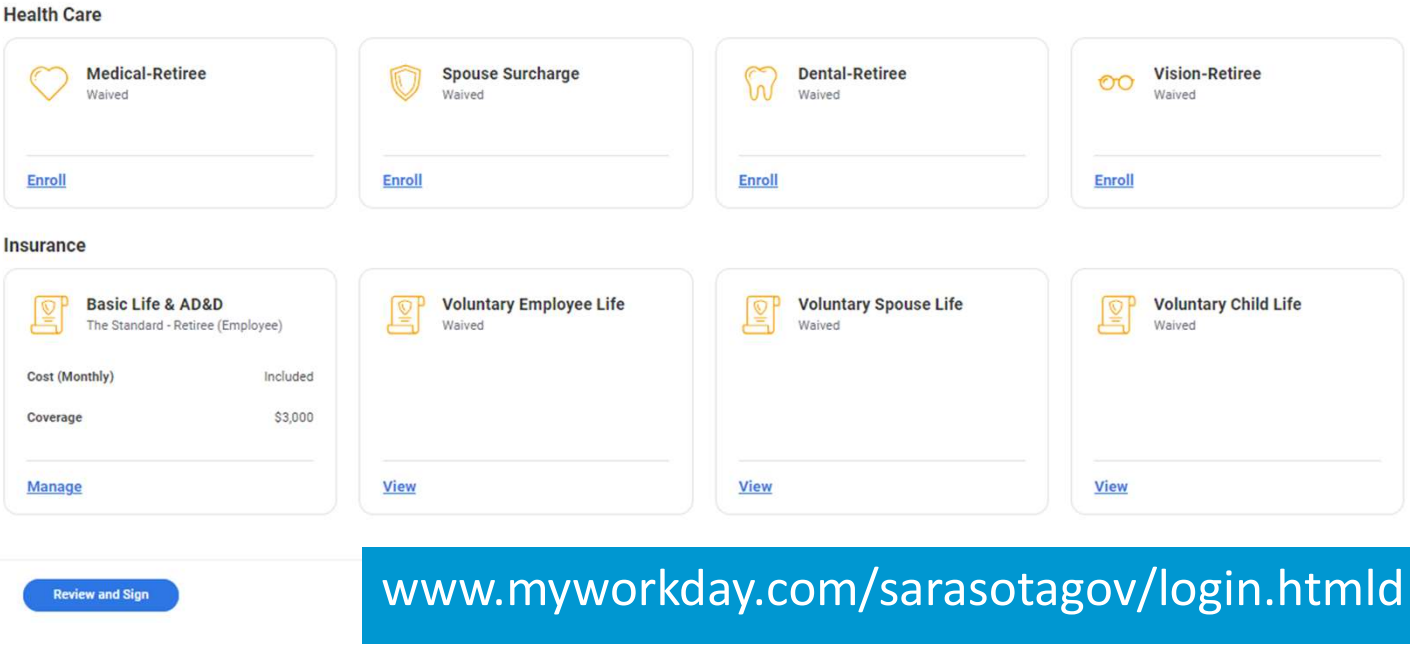
Initiating the Change Benefit Event

Qualifying Life Events

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.htmld

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

The City provides coverage, administered by Blue Cross Blue Shield, for eligible retirees and their dependents. The costs per pay period for coverage are listed in the premium table below. **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**

Plan 1 - HRA

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly *
Retiree Only	$151.75	$827.54
Retiree + One	$681.58	$1,650.86
Retiree + Family	$1,219.03	$2,885.84
Standalone Dependent (Not Medicare Eligible)	$620.66	Not Applicable

Plan 2 - HDHP w/ HSA or HRA (Under 65 retirees eligible for HSA, over 65 retirees will have an HRA)

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly *
Retiree Only	$0.00	$724.63
Retiree + One	$534.29	$1,436.92
Retiree + Family	$1,074.61	$2,372.81
Standalone Dependent (Not Medicare Eligible)	$543.47	Not Applicable

*The 2% COBRA administrator fee will be charged on the above rates.

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 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.

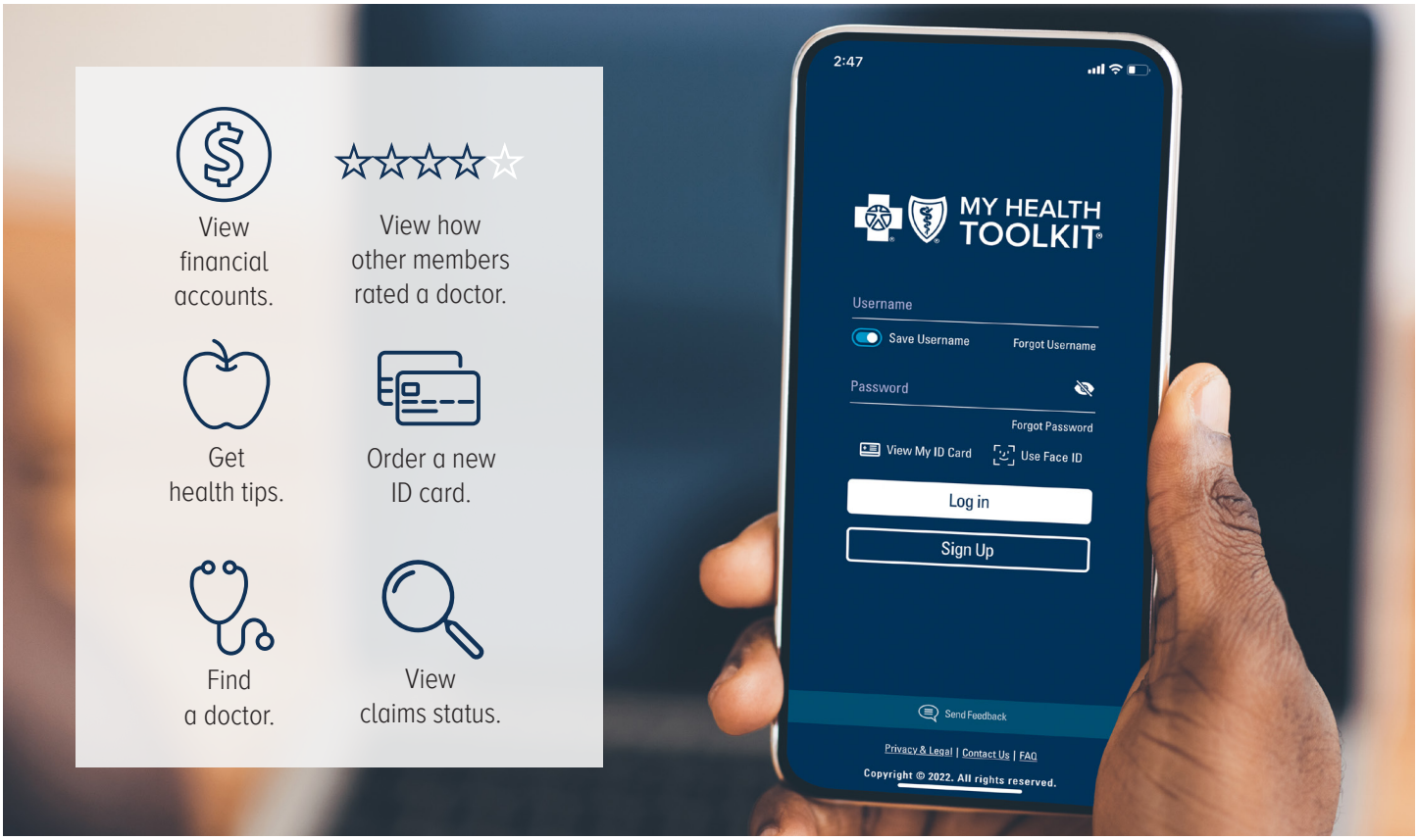
Call the number on the back of your membership ID card to speak to a **customer service advocate**.

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.

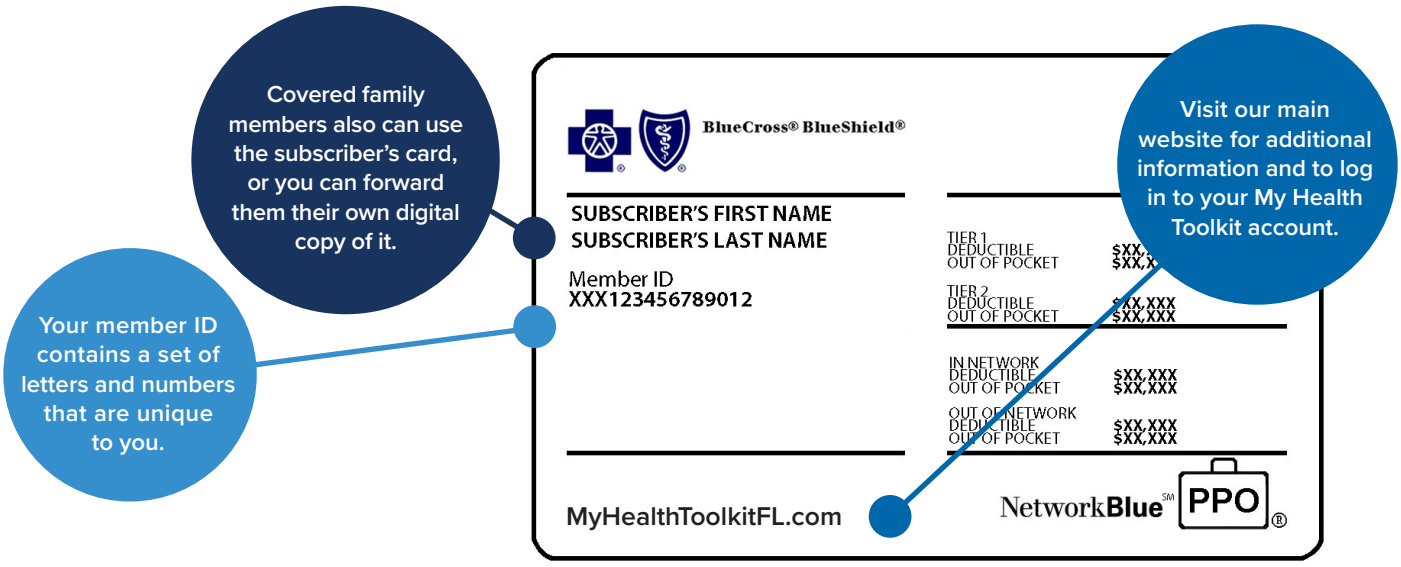
Primary care physician (PCP): The main doctor and primary contact for your health care services.

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

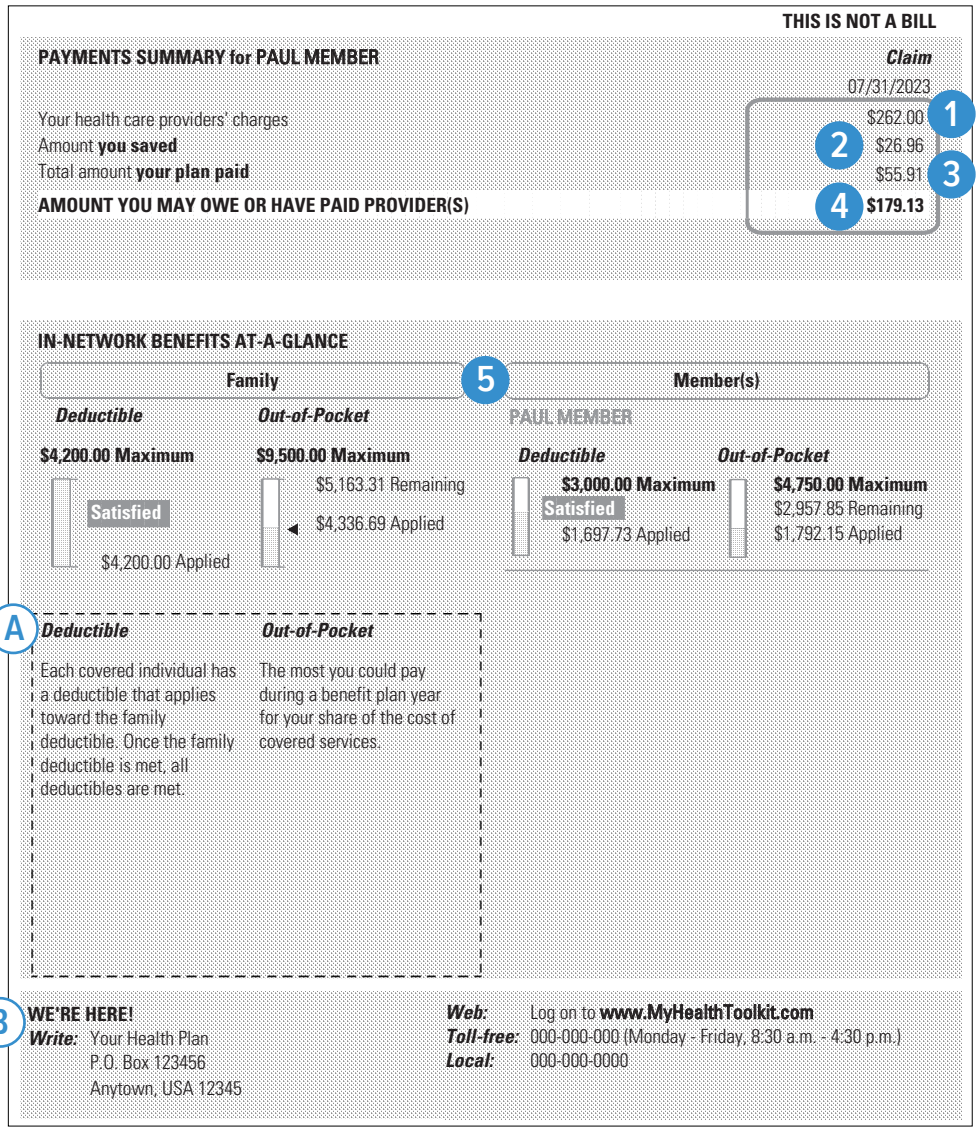
Whenever you use your health insurance, we send you an Explanation of Benefits (EOB). It shows you a breakdown of the services you received, the cost of those services and what you might have to pay your provider. **An EOB is not a bill**.

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

5

Family		Member(s) PAUL MEMBER	
Deductible	***Out-of-Pocket***	***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)

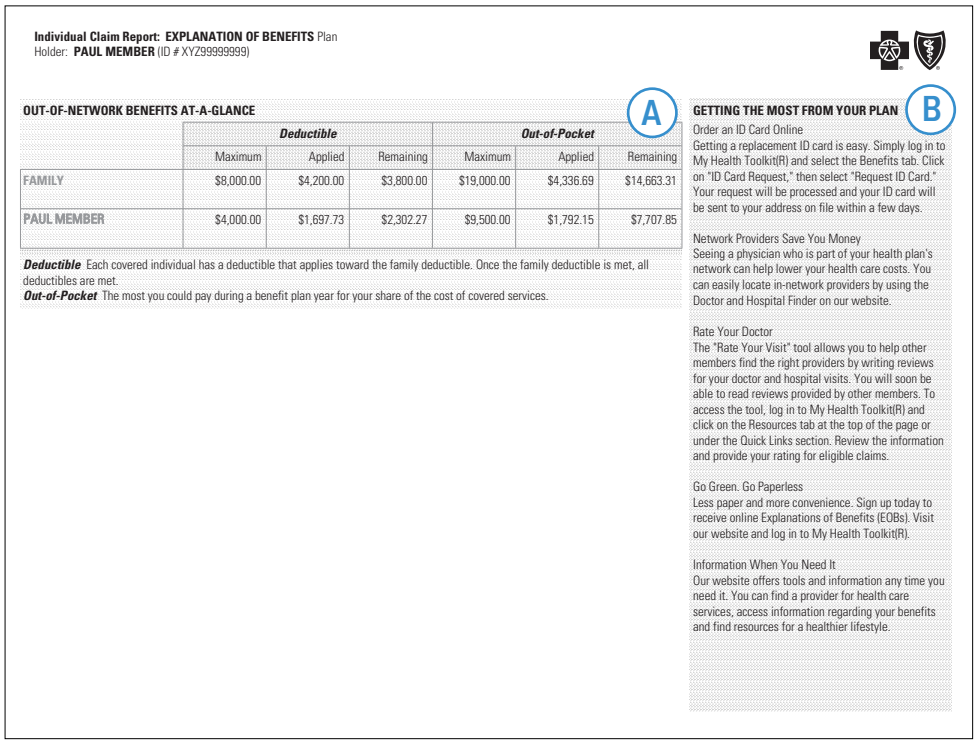
Plan Holder: PAUL MEMBER
(ID # XYZ999999999999)
Benefit Plan Year: 01/01/2023 - 01/01/2024
Notice Date: 08/07/2023

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)

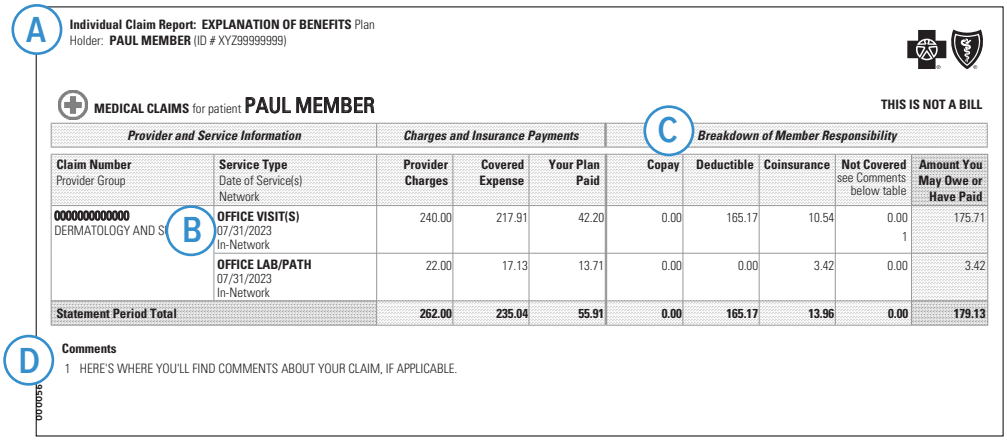
Order an ID Card Online
Getting a replacement ID card is easy. Simply log in to My Health Toolkit(R) and select the Benefits tab. Click on "ID Card Request," then select "Request ID Card." Your request will be processed and your ID card will be sent to your address on file within a few days.

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.

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.

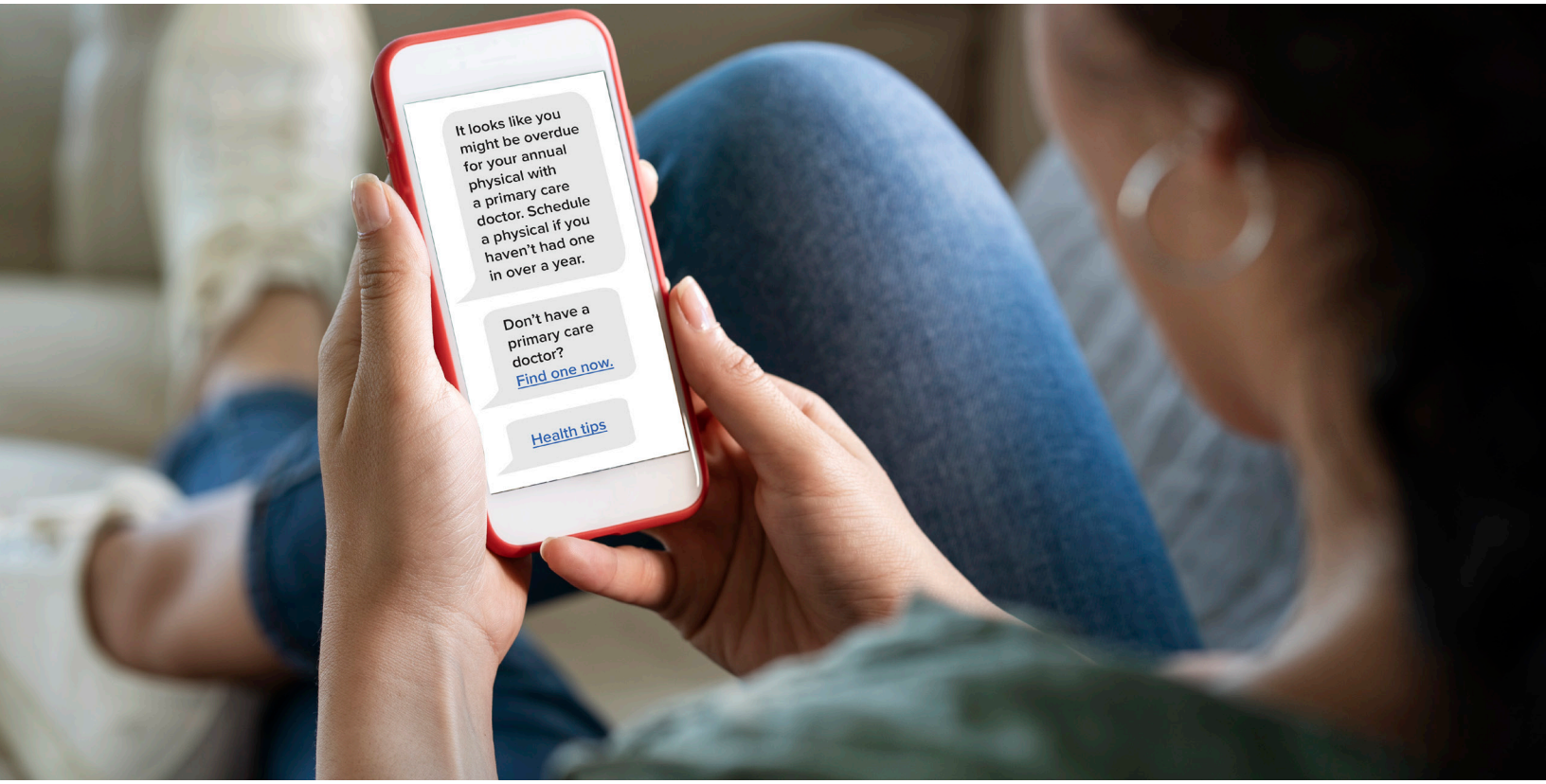
- For example, you might have declined coverage because other health insurance or another group health plan was in effect. Later, you may want to seek coverage with this plan if you or your dependents became ineligible for the other coverage or the employer stopped contributing to the other coverage. 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®:

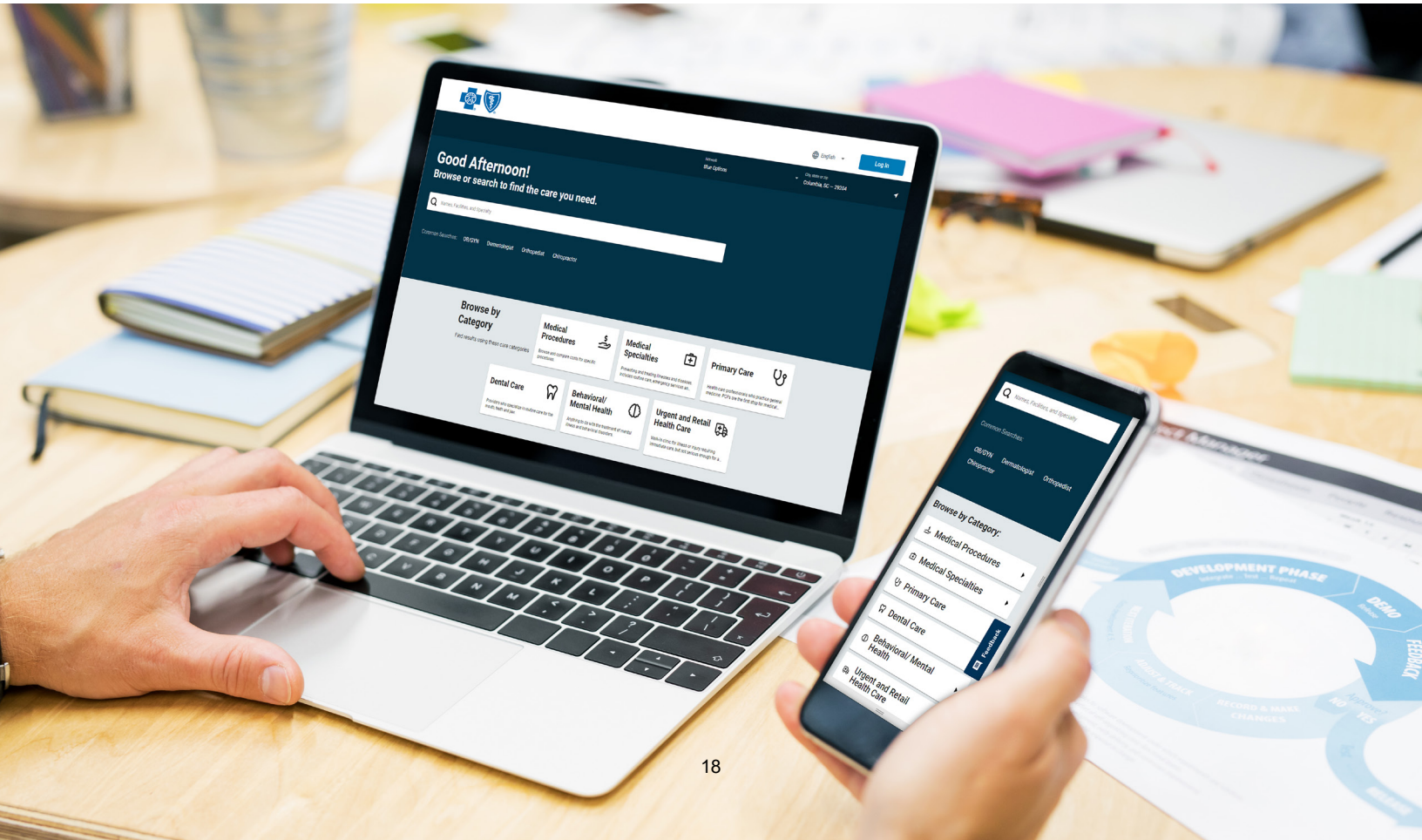
Access Shopping for Care from your computer:

- 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:

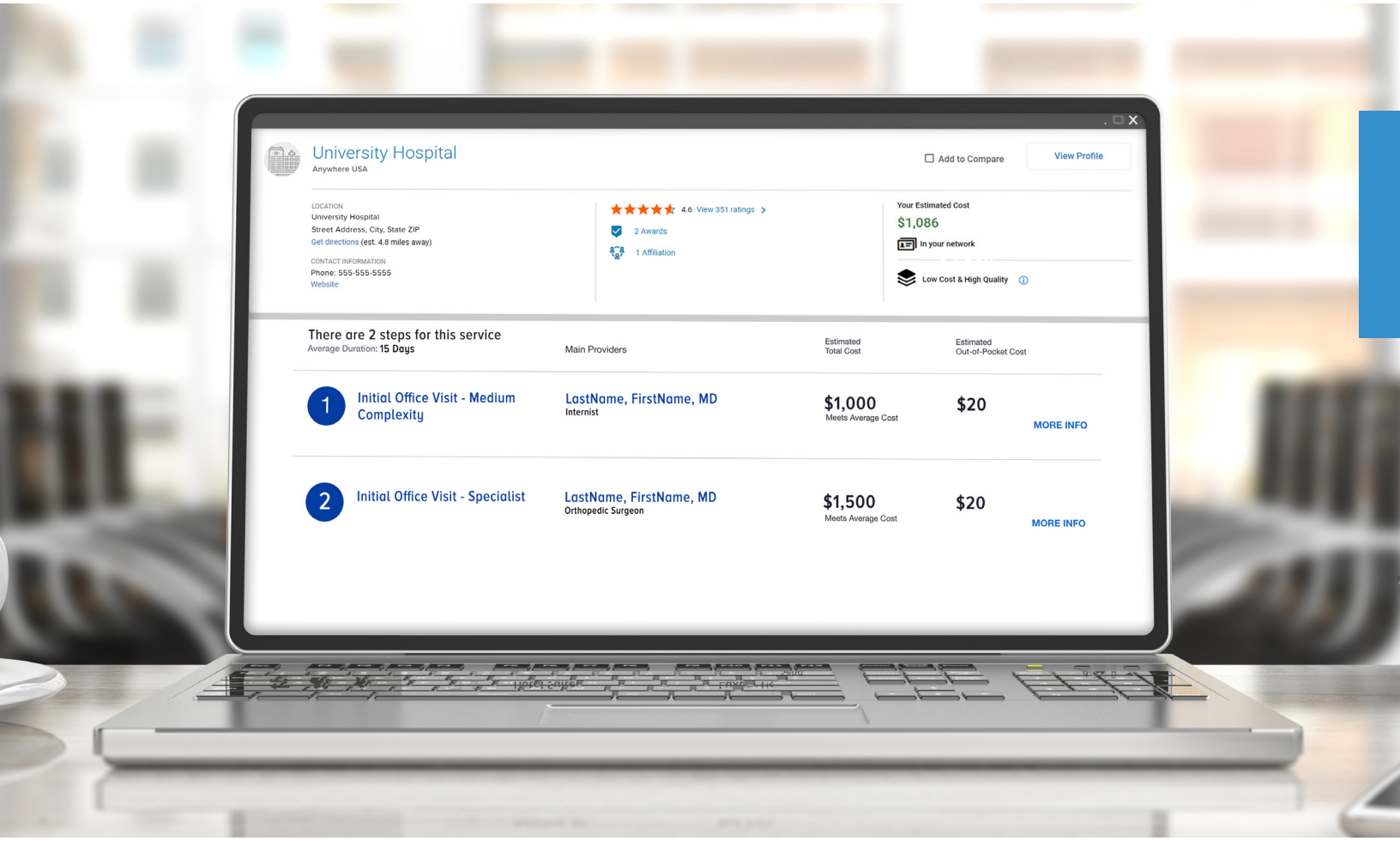
- Log in to the **My Health Toolkit** app from your mobile device.
- Select **Find Care**.

*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

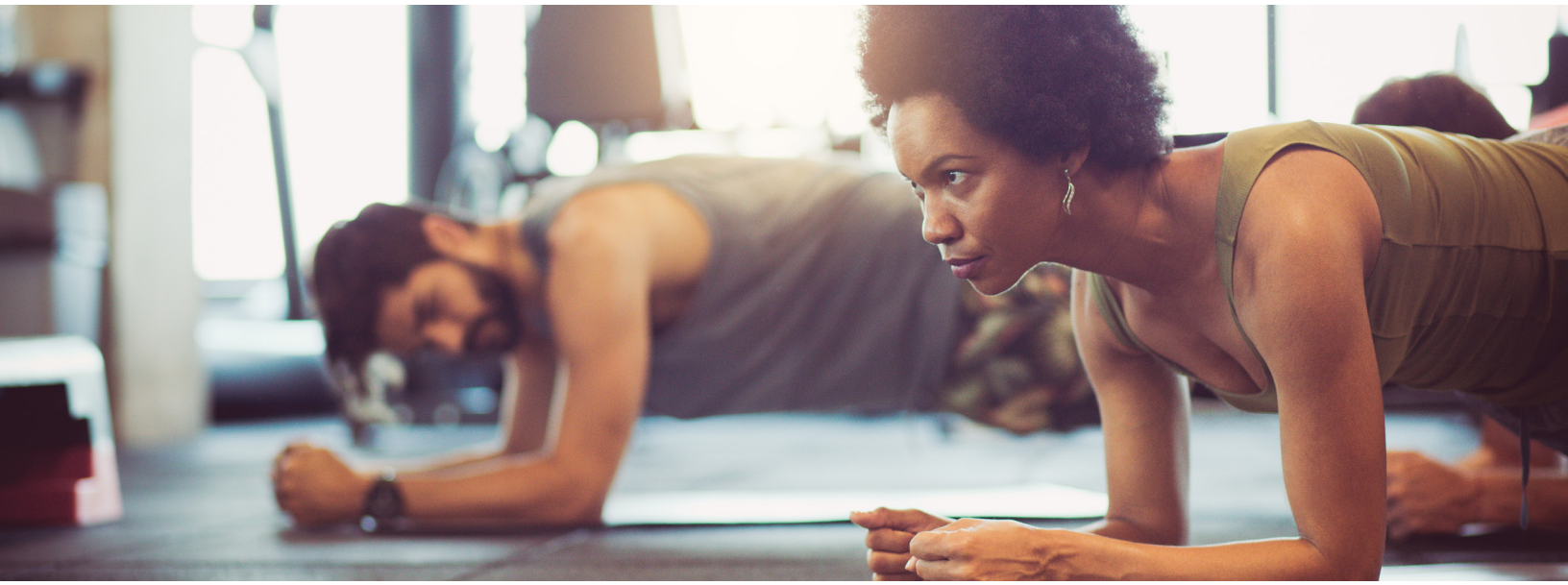
Lifestyle

- 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.

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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.

PRIOR AUTHORIZATION: MUSCULOSKELETAL CARE

Your health plan requires prior authorization for certain spine treatments, including surgeries and pain management services. If you are in an emergency room, prior authorization is not required.

What treatments require prior authorization?

Inpatient and outpatient surgeries:

- Lumbar microdiscectomy
- Lumbar decompression (laminotomy, laminectomy, facetectomy and foraminotomy)
- Lumbar spine fusion (arthrodesis)
- Cervical anterior decompression with fusion: single and multiple levels
- Cervical posterior decompression with fusion: single and multiple levels
- Cervical posterior decompression (without fusion)
- Cervical artificial disc replacement
- Cervical anterior decompression (without fusion)

Outpatient pain management services:

- Spinal epidural injections
- Paravertebral facet joint injections or blocks
- Paravertebral facet joint denervation (radiofrequency [RF] neurolysis)

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 might have to pay.

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 surgical procedures.
- Help you avoid paying unnecessary out-of-pocket expenses.

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.

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 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.

CVS caremark™
RxBenefits
Mobile app

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 retirees who complete the biometric screenings and are enrolled in the City of Sarasota's 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.

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

It is the **participant's responsibility** to return the Wellness Incentive Form to Human Resources or upload into Workday before the deadline. Current retirees' deadline to return the form to Human Resources is October 27, 2025. You can turn in your form by:

- Fax (941) 263-6336
- Email Fitzroy.Hibbert@sarasotafl.gov
- Mail to 111 S. Orange Ave., Suite 204, Sarasota, FL 34236

UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE

The City provides coverage, administered by AARP / UnitedHealthcare, for eligible retirees and their dependents. This plan is available to retirees that are Medicare eligible. You must be enrolled in Medicare Part A & Part B as a retiree. The costs per month for coverage are listed in the premium table below. Retirees (Pre-93 Hire) can continue to use the Health Center if enrolled in the Medicare Advantage Plan. **For information about your medical plan, please refer to the benefit summary on our website at Sarasotafl.gov/government/human-resources or contact AARP Customer Service at (866) 658-8344.**

Retiree Medicare Advantage Plan (PPO) for 2025

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly
Retiree Only (Age 65+)	$0.00	$523.27
Retiree's Spouse (Age 65+)	$523.27	$523.27

UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE

Benefit Name	In Network	Out of Network
Annual Deductible	None	None
Annual Out of Pocket Maximum	$0	$0
Primary Care Physician Office Visit	$0	$0
Specialists Office Visit	$0	$0
Virtual Office Visit	$0	Not Covered
Telemedicine	$0	$0
Emergency Room	$0	$0
Urgent Care Facility	$0	$0
Clinical Laboratory Services	$0	$0
Outpatient X-ray Services	$0	$0
Diagnostic Radiology Service	$0	$0
Inpatient Hospital Stay	$0	$0
Outpatient Hospital	$0	$0
Durable Medical Equipment	$0	$0
Diabetic Shoes & Inserts	$0	$0
Routine Hearing Exam for Hearing Aids	$0	$0
Hearing Aid Allowance - includes digital hearing aids. Benefit is for ears combined.	$500	
Ambulance	$0	$0
Routine Vision Exam (Every 12 months)	$0	$0
Physician Services at Outpatient Hospital or Surgical Center	$0	$0
Mental Health / Alcohol & Substance Abuse		
Inpatient	$0	$0
Outpatient Facility	$0	$0
Physician Office Visit	$0	$0
Prescription Drugs		
Tier 1– Generic	$5	Not Covered
Tier 2 – Preferred Brand Name	$10	
Tier 3 – Non-Preferred Brand Name	$20	
Tier 4 – Specialty Drugs	$20	
Mail-Order Program (90 Day Supply)	$10 / $20 / $40 / $40	

PRE-1993 RETIREE REIMBURSEMENT STIPEND

Pre-93 retirees have the option to enroll in the Stipend program. This allows the retiree to enroll in a medical plan outside of the City self-funded plan and United Healthcare Medicare Advantage option and receive funds (submit receipts for reimbursement) to pay for the medical plan premium. The amount that will be reimbursed will match the City of Sarasota's United Health Care Advantage Plan. The Stipend plan covers medical premiums, prescriptions, and dental claims (receipts must be submitted to vendor in order to receive reimbursement for each expense). This plan is only for Pre-93 retirees and does not include spousal coverage. If a Pre-93 Spouse is not yet Medicare eligible, they can remain on the City's Blue Cross medical plan as a standalone dependent. The cost is $620.66 per month for Plan 1-HRA or $543.47 per month for Plan 2-HSA.

Retiree Reimbursement Stipend for 2025

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Monthly Stipend Reimbursement Amount
Retiree Only	$523.27

Documentation is required to be submitted to Human Resources showing the effective date of the plan.

METLIFE DENTAL INSURANCE

The City offers dental insurance administered by MetLife. The cost per month 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 and type in City of Sarasota**.

Base Plan 1 Dental PPO

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly**
Retiree Only	$5.49	$35.00
Retiree + One	$10.97	$65.00
Retiree + Family	$16.45	$95.00

Buy Up Plan 2 Dental PPO

Tier of Coverage	Retiree (Pre 10/01/93 Hire) Cost Monthly	Retiree (Post 10/01/93) & Surviving Spouse Cost Monthly**
Retiree Only	$11.54	$42.14
Retiree + One	$21.47	$78.26
Retiree + Family	$31.37	$114.38

**The 2% COBRA administrator fee is 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

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 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	Retiree Cost Monthly**
Retiree Only	$5.60
Retiree + One	$10.63
Retiree + Family	$13.86

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 is charged on the above rates.

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 Provider.
MetLife does NOT provide ID cards.

MetLife

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

CANARX PRESCRIPTION DRUG PROGRAM

The City of Sarasota offers a prescription drug benefit through CANARX. CANARX is a voluntary Name Brand (only) prescription drug program that is available to eligible retirees and their dependents on the Blue Cross Blue Shield medical plan.

All member copayments have been waived for this program only.

- $0.00 co-pay for all prescriptions offered through the program. Check formulary for available medications.
- Prescriptions shipped directly to your home with no shipping and handling costs.
- No out-of-pocket expenses.
- Before ordering through CANARX, you or your doctor must attest that you have been taking your prescribed medication for at least 30 days – this is to ensure you have not experienced any complications with the medication.

Getting started is super easy!

1. Check to see if a medication is offered. Call **1-866-893-6337** and speak with a CANARX representative or view the complete formulary and print enrollment material at **www.canarx.com** (**WebID: SARASOTA**).
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit Your Completed and Signed Enrollment Form, Original Prescription and copy of your Legal Photo ID by one of the following methods:
   - Mail:
     CANARX
     PO BOX 3009
     Windsor, ON CANADA
     N8N 2M3
   - Secure Upload: CANARXDOCS.COM
   - Fax: 1-866-715-6337 (NOTE: Faxed prescriptions must be sent directly from the physician's office.)
4. Sit back and relax…medication will be mailed direct to your home within 4 weeks!

Visit the www.canarx.com (WebID: SARASOTA) for more information including:

- Additional Forms
- Frequently Asked
- Questions (FAQs)
- Video Overview
- List of Medications

CANARX

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

STANDARD LIFE INSURANCE

Basic Term Life & Accidental Death & Dismemberment Insurance

Eligible retirees (hired prior to October 1, 1993 and retire after January 1, 2025) are provided $3,000 of Basic Term Life coverage.

Voluntary Life Insurance

Voluntary Life insurance is **only available if additional voluntary term life coverage with Standard Insurance Company is in force at the time of retirement.** Retirees may not add additional insurance on themselves through Standard Life at a later date. Voluntary Life insurance offers coverage for yourself, your spouse and/or child(ren) at set benefit levels.

- Units can be purchased for the retiree in the amounts of $7,000 or $17,000.
- Premium are based on age and coverage level.
- Premiums are not locked in and increase when age bands are crossed.

Retiree Voluntary Life		
Retiree Age	**Monthly Rates per $7,000**	**Monthly Rates per $17,000**
<30	0.42	1.02
30-34	0.56	1.36
35-39	0.63	1.53
40-44	0.84	2.04
45-49	1.47	3.57
50-54	2.59	6.29
55-59	4.27	10.37
60-64	5.25	12.75
65-69	9.17	22.27
70-74	14.42	35.02
75 & over	15.61	37.91

Voluntary Spouse/Dependent Child Life Insurance

May be converted to $1,500 for spouse and/or dependent at the time the employee retirees. The policy must have been in force already. Cost is a flat monthly rate of $1.50.

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**.

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

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 & Health Savings Account	Accrue Health	844-643-3099
Prescription Drug & Mail Order Program	RxBenefits	(800) 334-8134
Medicare Advantage PPO Plan	UnitedHealthcare / AARP	(866) 658-8344
Telehealth– Virtual Visits	Teladoc	(866) 789-8155
Retiree Health Center	Marathon	(941) 893-2556
Dental	MetLife	(800) 942-0854
Vision	MetLife	(855) 638-3931
Life	The Standard	(800) 348-3226
Free Prescription Drug Program	CanaRx	(866) 893-6337
Escalated Medical & Dental Claims Issues	Brown & Brown	Dani Hochmuth danielle.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

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

OE-FL-7-2022