Benefits at a Glance Handbook

OCTOBER 1, 2016 – SEPTEMBER 30, 2017

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Employee Benefit Summary 2016-2017

The City of Ocala is pleased to offer a comprehensive benefits program, which allows you to select plans based on your individual needs. This guide is intended to be a tool for you to use to make an informed choice about the benefit plans that best suit you and your family.

This Benefits at a Glance handbook is designed to provide basic information to employees on employee benefit plans and programs available October 1, 2016 — September 30, 2017 through the City of Ocala. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contracts or the Summary Plan Descriptions (SPDs). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Eligibility & Qualified Life Events

You are eligible to participate in the benefits program if you are a regular full-time employee. For purposes of the medical benefits, you are considered full-time if you normally work a minimum of 30 hours each week. Your medical insurance benefits begin on the first of the month following 30 days of employment. For purposes of all the other employee insurance benefits, you are considered full-time if you normally work a minimum of 40 hours each week.

Who is an Eligible Dependent Spouse?

Your spouse under a legally valid existing marriage.

Who is an Eligible Dependent Child under the medical benefit?

Your natural, newborn, adopted, foster, or step child(ren) (or a child for whom you have been court-appointed as legal guardian or legal custodian) who has not reached the end of the calendar year in which he or she reaches age 30 (or in the case of a foster child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on you, whether the dependent child resides with you, or whether the dependent child is eligible for or enrolled in any other group health plan. A dependent child may also remain covered after age 30 provided the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap. (medical documentation required).

Please refer to the specific benefit plan page in this handbook for dependent eligibility for the purposes of all other employee insurance benefits.

Changes after Open Enrollment

Benefits with pre-tax deductions are governed by the IRS code Section 125. This regulation does not allow you to change your benefit selections during the year UNLESS you experience a Qualifying Life Event (QLE). If you experience a QLE, you will have to provide proof of the QLE to the HR & Risk Department.

Qualifying Life Event (QLE)

All QLEs must be reported within 30 days of the occurrence and documentation is required in order to be eligible to make a change to your benefit enrollments.

Qualified Life Events Include but are not limited to :

- Marriage, legal separation or divorce
- Birth/adoption/legal guardianship of a child
- Dependent satisfies or ceases to satisfy eligibility requirements
- Spouse's employer's Open Enrollment
- Termination of your spouse's employment
- Unpaid leave of absence
- Change in full or part time status
- Changes due to a judgment, decree or court order
- Entitlement to Medicare or Medicaid
- Enrollment on the Marketplace Exchange

Section 125 - Pre Tax Benefits

The City of Ocala sponsors a cafeteria plan also known as a Section 125 plan. Medical, dental, vision benefit premiums and FSA contributions are taken out of your paycheck on a pre-tax basis, i.e., before taxes are taken out. Doing so reduces your taxable income thereby decreasing your taxes and increasing your take home pay. With after-tax contributions, just the opposite is true. Premiums are deducted from your pay after Federal and Social Security taxes are calculated and deducted from your gross pay. The chart below shows the tax treatment of the benefits which you elect:

Benefit	Tax Treatment
Medical Coverage	Pre-tax
Dental Coverage	Pre-tax
Vision Coverage	Pre-tax
Basic Life and AD&D Insurance	N/A—paid by the City
Supplemental Life and AD&D Insurance	After-tax
Long Term Disability—Emergency Personnel and All Other Personnel	After-tax
Flexible Spending Accounts	Pre-tax
Allstate Cancer Policy	Pre -tax
USAble Accident Policy	After-tax
USAble Critical Care Policy	After-tax

PAYING FOR YOUR BENEFITS WHILE ON AN APPROVED MEDICAL LEAVE— FMLA OR LEAVE RELATED TO A WORKCOMP INJURY

Employees eligible for continuation of benefits while on an approved leave are still responsible to pay the same portion of premiums paid prior to the leave.

You may pay your portion of premiums due before starting your leave or you may pay monthly during your leave. Payment is due on or before the first of the month.

Failure to make payments in a timely manner will result in your termination of coverage. You should contact your HR & Risk Management Department to make payment arrangements prior to your leave.

Benefit Termination

Your benefits will terminate on the last day of the month you elect not to participate in the plan, or cease to be a benefits eligible employee. The only exception to this rule is the Life Insurance coverage.

The Consolidated Budget Reconciliation Act (COBRA) provides insured employees and their qualified beneficiaries the opportunity to continue health, dental and vision insurance coverage when a “qualifying event” would normally result in the loss of coverage eligibility.

The City’s Cobra Administrator, TASC, will provide you with the cost and information necessary to make your cobra elections.

How to Enroll

BenTek is the City of Ocala's enrollment vendor and name of the online enrollment system. All new hires, employees with qualifying events and benefit eligible employees during open enrollment must access BenTek for their elections and waivers.

1. Log on to ***www.mybentek.com/cityofocala***.
2. If you are a first time user, follow the instructions to set up your user name and password.
3. Please record your user name and password to retrieve it in the future.
4. Check that your dependents and life beneficiaries are recorded and up to date.
5. Follow the prompts to make your elections.
6. Click on "**Submit**" at the end of your session to save your elections.
7. Print your election confirmation page (recommended).

Accessible 24 hours a day, you can log on to BenTek to:
- Learn about your benefit options
- Review information about all of your payroll deductions
- Access carrier contact information and carrier links
- Download and print forms

If any technical questions arise while visiting BenTek,
please e-mail BenTek Support at **support@mybentek.com**
or call **(888) 5-BenTek (523-6835)**,
Monday through Friday, 8:30am to 5:00pm EST.

MEDICAL PLANS

BlueOptions™ PPO:

Your Florida Blue BlueOptions™ PPO health insurance policy offers members the freedom to choose any doctor and hospital for care. However, you can maximize your benefits and free yourself from claims filing and balance billing by choosing physicians and providers who participate in the Blue Options provider network.

The BlueCard® Program for BlueOptions (PPO) Members:

BlueOptions™ gives you the freedom of knowing you're covered no matter where you go in the U.S. If you have a child attending school outside the state, or if you're traveling throughout the U.S. on business or pleasure, the BlueCard® Program allows your benefits to travel with you. If you or a family member become ill when outside the state of Florida, just call 1-800-810-BLUE (2583) for the name of a participating BlueCard PPO provider. When you arrive at the facility, simply show your Florida Blue ID card and you'll receive the same health care coverage you enjoy at home. You won't have any claims to file or billing hassles down the road. Simply pay the appropriate deductible, co-payment or coinsurance at the time of service.

Co-payment:

A flat dollar amount that you pay for certain services and prescription drug services, regardless of the actual amount charged by your doctor or another provider.

Deductible:

The amount you pay toward medical expenses each calendar year before the plan begins sharing in the cost of certain benefits.

Co-insurance:

The percentage split of the covered charge shared by you and the insurance carrier that is paid after you've met the deductible. For example: 80% paid by the insurance carrier, 20% paid by you once the deductible has been satisfied.

Out-of-Pocket Maximum:

The maximum amount you will pay for health care costs in a calendar year. Once you have paid the out-of-pocket maximum, consisting of your deductible, coinsurance and certain co-payments, the plan will cover the remaining eligible medical expenses at 100% for the rest of the calendar year.

How to Locate Participating Providers:

Find A Doctor is Florida Blue's on-line provider directory resource. You can locate participating physicians, hospitals and other providers in a matter of seconds.

⇒ To use **Find A Doctor,** go to www.floridablue.com

⇒ Click on "**Find a Doctor & More**"

⇒ Step 1: From the pull down menu, choose "BlueOptions", your plan network of participating providers

⇒ Step 2: Enter the location of the area you wish to receive services

⇒ Click on the **"Search"** button and a list of the providers will generate based on the criteria you entered

PREVENTIVE HEALTH SERVICES

The preventive health services described below are covered at no cost to you when using In-Network Providers. Care must be submitted to Florida Blue as "Preventive Care" by the provider and if a diagnosis results, the care will be subject to the applicable diagnostic care benefits.

Age and frequency schedules apply:

- Routine Adult Physicals / Immunizations
- Well Child Exams / Immunizations
- Routine Gynecological Exams
- Routine Mammograms
  (1 baseline for females 35-39; 1 annual mammogram for females age 40 and over)
- Routine Digital Rectal Exams / PSA Testing
- Colorectal Cancer Screening for Members age 50+

FLORIDA BLUE 365 DISCOUNT SERVICES

Florida Blue offers its members a program of products and services to help offset the rising costs associated with healthcare by offering discounts on a variety of products and services.

Go to **https://www.blue365deals.com/** for information on these discounts, including:

- Enhanced vision care discount program
- Weight management programs
- **Family health & wellness facilities**
- **Fitness centers**
- Hearing aid discount programs

FLORIDA BLUE

MEMBER WEBSITE

The Florida Blue member portal is a personalized web portal designed to help provide answers to some of your most common health needs. For information on registering for this free service, visit www.foridablue.com. Your unique and confidential user identification code and password gives you access to your personal benefit information 24 hours a day, 7 days a week. You have direct access to:

- Find a doctor or hospital in your plan
- See what is covered and what you'll pay
- Order ID cards
- See statements of what was paid
- Get health information for your symptoms
- Start a Health Assessment or Lifestyle Program

How to Register

⇒ Go to www.floridablue.com and click on **Members.**
⇒ Click on the **"Login Now"** link.
⇒ Select a User Name, Password and a Security Phrase.
⇒ Once your registration is complete your user name and password will give you access to all the features of the member portal.

HEALTH DIALOG

HEALTHY ADDITION PRENATAL EDUCATION PROGRAM

Healthy Addition is Florida Blue's prenatal education and early intervention program. It is designed to educate pregnant employees or eligible spouses about the appropriate prenatal care. Under this voluntary program, trained nurses will screen pregnant employees or eligible spouses for potential risk factors and assist in the development of a personalized educational and monitoring program. To participate in the Healthy Addition program, call Florida Blue customer service at 1-877-352-2583. A member of the prenatal nursing team will contact you or your spouse to begin helping you with your new family addition.

MEDICAL CASE MANAGEMENT PROGRAM

Through this program, Florida Blue helps coordinate alternative treatments when a covered person is faced with a serious or complicated medical condition. These alternative treatments may include services that are not usually covered by this health insurance plan.

The medical case management program is voluntary. A Healthcare professional will review the case with the patient's family and doctor and, if appropriate, suggest an alternative treatment plan. The patient and the patient's doctor must agree to the suggested treatment plan.

If the patient's alternative treatment plan is approved by Florida Blue, recommended services will be paid at 100% of the charge negotiated by Florida Blue.

The case management alternative treatment plan will end if:

- The patient's condition changes and the level of care provided under case management is no longer necessary.
- The case management approach costs more than traditional benefits.
- The patient is no longer eligible to take part in this health insurance plan.

	Blue Options Plan 03359	Blue Options Plan 05902
Monthly Rates		
EE with Wellness	$47.44	$0.00
EE without Wellness	$72.00	$20.00
EE/Family with Wellness	$226.96	$150.46
EE/Family without Wellness	$285.00	$194.00

Please remember your HRA is to be completed (both appointments) NO LATER THAN September 30, 2016. If it is not completed, by both yourself and your spouse, you will be changed to the Without Wellness premium beginning the first paycheck in October.
To schedule an appointment with CareHere please call 1-877-423-1330 or go to https://www.myhealthguide.com/lab/reg2/utility

PLAN DETAILS

COST SHARING Maximums Shown are Per Benefit Period (BPM) unless noted	Blue Options Plan 03359	Blue Options Plan 05902
Deductible (DED) (Per Person/Family Agg) In-Network Out-of-Network **Coinsurance (Member Responsibility)** In-Network Out-of-Network	 $1,500 / $3,000 $1,500 / $3,000 30% 50%	 $2,500 / $5,000 $2,500 / $5,000 20% 50%
Out-of-Pocket Maximum (Per Person/Family Agg) In-Network Out-of-Network	Includes DED, Coins, Copays $3,000 / $6,000 $5,000 / $10,000	Includes DED, Coins, Copays $5,000 / $10,000 $10,000 / $10,000
Lifetime Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections In-Network Family Physician In-Network Specialist Out-of-Network	 $10 DED + 30% DED + 50%	 $10 DED + 20% DED + 50%
E-Office Visit Services In-Network Family Physician In-Network Specialist Out-of-Network	 $10 $10 DED + 50%	 DED + 20% DED + 20% DED + 50%
Office Services In-Network Family Physician In-Network Specialist Out-of-Network	 $30 $60 DED + 50%	 $40 $100 DED + 50%
Provider Services at Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 30% DED + 30% In-Ntwk DED + 30%	 DED + 20% DED + 20% ONN DED + 20%
Provider Services at Other Locations In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 30% DED + 30% DED + 50%	 DED + 20% DED + 20% DED + 50%

Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center or Hospital In-Network Specialist Out-of-Network	ASC: DED + 30% Hospital: DED + 30% In-Ntwk: DED + 30%	ASC: DED + 20% Hospital: DED + 20% In-Ntwk: DED + 20%
Medical Pharmacy Monthly In-Network OOP Max (Provider-Administered Rx)* In-Network Out-of-Network	$200 monthly OOP max applies after deductible 20% (after DED) DED + 50%	$200 monthly OOP max applies after deductible 20% (after DED) DED + 50%
PREVENTATIVE CARE		
Adult Wellness Office Services In-Network Family Physician In-Network Specialist Out-of-Network	$0 $0 $0	$0 $0 $0
Colonoscopies (Routine) In-Network Out-of-Network	Age 50+ then Frequency Schedule Applies $0 $0	Age 50+ then Frequency Schedule Applies $0 $0
Mammograms (Routine and Dx) In-Network Out-of-Network	$0 $0	$0 $0
Well Child Office Visits (No BPM) In-Network Family Physician In-Network Specialist Out-of-Network	$0 $0 50% (No DED)	$0 $0 50% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance Maximum (combined ground, air and water - per day) In-Network Out-of-Network	$5,500 DED + 30% In-Ntwk DED + 30%	$5,500 DED + 20% In-Ntwk DED + 20%
Convenient Care Centers (CCC) In-Network Out-of-Network	$25 DED + 50%	DED + 20% DED + 50%
Emergency Room Facility Services (also see Professional Provider Services) In-Network Out-of-Network	$300 $300	DED + 20% OON DED + 20%
Urgent Care Centers (UCC) In-Network Out-of-Network	$35 DED + 50%	$45 DED + 50%
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.		
Ambulatory Surgical Center In-Network Out-of-Network	$100 DED + 50%	DED + 20% DED + 50%
Independent Clinical Lab In-Network Out-of-Network	$0 DED + 50%	$0 DED + 50%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services) In-Network - Advanced Imaging Services (AIS) In-Network - Other Diagnostic Services Out-of-Network	$200 $0 DED + 50%	DED + 20% DED + 20% DED + 50%
Inpatient Hospital (per admit) In-Network Out-of-Network	DED + 30% DED + 30% DED + 50%	DED + 20% DED + 20% DED + 50%
Inpatient Rehab Maximum	21 Days	21 Days
Outpatient Hospital (per visit) In-Network Out-of-Network	DED + 30% DED + 30% DED + 50%	DED + 20% DED + 20% DED + 50%

Therapy at Outpatient Hospital In-Network Specialist Out-of-Network	 Option 1 - $45 Option 2 - $60 DED + 50%	 DED + 20% DED + 20% DED + 50%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization In-Network Out-of-Network	 Option 1 - $0 Option 2 - $0 40% (No DED)	 Option 1 - $0 Option 2 - $0 50% (No DED)
Outpatient Hospitalization (per visit) In-Network Out-of-Network	 Option 1 - $0 Option 2 - $0 40% (No DED)	 Option 1 - $0 Option 2 - $0 50% (No DED)
Provider Services at Hospital and ER In-Network Out-of-Network	 $0 $0	 $0 $0
Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider	 $0 40% (No DED)	 $0 50% (No DED)
Emergency Room Facility Services (per visit) In-Network Out-of-Network	 $0 $0	 $0 $0
Provider Services at Locations other than Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider	 $0 40% (No DED)	 $0 50% (No DED)
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office In-Network Family Physician In-Network Specialist Out-of-Network	 $150 $150 DED + 50%	 DED + 20% DED + 20% DED + 50%
Birthing Center In-Network Out-of-Network	 DED + 30% DED + 50%	 DED + 20% DED + 50%
Durable Medical Equipment, Prosthetics, Orthotics BPM In-Network Out-of-Network	Enteral Formulas: $2,500 All Other: No Maximum DED + 30% DED + 50%	Enteral Formulas: $2,500 All Other: No Maximum DED + 20% DED + 50%
Home Health Care BPM In-Network Out-of-Network	30 Visits DED + 30% DED + 50%	30 Visits DED + 20% DED + 50%
Hospice LTM In-Network Out-of-Network	No Maximum DED + 30% DED + 50%	No Maximum DED + 20% DED + 50%
Outpatient Therapy and Spinal Manipulations BPM	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM In-Network Out-of-Network	90 days DED + 30% DED + 50%	90 days DED + 20% DED + 50%
PRESCRIPTION DRUGS		
Deductible	$100 Brand Only	$200 Brand Only
In-Network **Retail (30 days)** Generic/Preferred Brand/Non-Preferred Brand **Mail Order (90 days)** Generic/Preferred Brand/Non-Preferred Brand	 $10 / $30 / $45 $20 / $60 / $90 No RX deductible	 $20 / $40 / $60 $40 / $80 / $120 RX deductible applies
Out-of-Network **Retail (30 days)** Generic/Preferred Brand/Non-Preferred Brand **Mail Order (90 days)** Generic/Preferred Brand/Non-Preferred Brand	 50% / 50% / 50% 50% / 50% / 50%	 50% / 50% / 50% 50% / 50% / 50%
Specialty Pharmacy/Drugs (30 days) **CareMark - 1-866-278-5108** In-Network—CareMark Out-of-Network	12 $10 / $30 / $45 50% / 50% / 50%	 $20 / $40 / $60 50% / 50% / 50%

DENTAL BENEFITS

MetLife

Network: PDP Plus

	Plan Option 1 High Plan		Plan Option 2 Low Plan	
Coverage Type	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Type A – cleanings, oral examinations	100% of Negotiated Fee	100% of R&C Fee	100% of Negotiated Fee	90% of R&C Fee
Type B – fillings	80% of Negotiated Fee	80% of R&C Fee	80% of Negotiated Fee	60% of R&C Fee
Type C –bridges and dentures	50% of Negotiated Fee	50% of R&C Fee	50% of Negotiated Fee	40% of R&C Fee
Type D – orthodontia	50% of Negotiated Fee	50% of R&C Fee	50% of Negotiated Fee	50% of R&C Fee
Deductible				
Individual	$50.00	$50.00	$50.00	$50.00
Family	$150.00	$150.00	$150.00	$150.00
Annual Maximum Benefit				
Per Person	$1,000	$1,000	$1,000	$1,000
Orthodontia Lifetime Maximum				
Per Person	$1,000	$1,000	$1,000	$1,000

Rates (monthly)	High Plan	Low Plan
Employee	$36.15	$26.42
Employee +1 Dependent	$56.11	$40.98
Employee +2 or more Dependents	$88.53	$64.65

* Dependent children are eligible for coverage up until the end of the calendar year in which the dependent turns age 30.

Common Questions... Important Answers

How do I find a participating dentist? There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at www.metlife.com or call 1-800-942-0854 to have a list faxed or mailed to you.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He or she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

List of Primary Covered Services	Plan Option 1 – High Plan	Plan Option 2 – Low Plan
Type A – Preventive How Many/How Often		
Prophylaxis (cleanings)	• Two time in 12 months	• Two time in 12 months
Oral Examinations	• Two time in 12 months.	• Two time in 12 months.
Topical Fluoride Applications	• Once in 36 months	• Two times in 12 months for a dependent child under age 14.
X-rays	• Full mouth X-rays: one in 36 months. • Bitewing X-rays: one set in 12 months for adults; one set in 12 months for children under age 19	• Full mouth X-rays: one per 60 months. • Bitewing X-rays: one set per calendar year for adults; two sets per calendar year for children.
Space Maintainers	• .One per lifetime for a child under age 14	• .One per lifetime for a child under age 14
Type B - Basic Restorative How Many / How Often		
Simple Extractions	• Unlimited	• Unlimited
Endodontics	• Root canal treatment limited to one per tooth per lifetime	• Root canal treatment limited to one per tooth per lifetime
General Anesthesia	• Unlimited	• Unlimited.
Oral Surgery	• Unlimited	• Unlimited
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year.	• Periodontal scaling and root planing once per quadrant, every 24 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year.
Sealants	• One application of sealant material every 36 months for each non- restored, non-decayed 1st and 2nd molar of a dependent child up to age 16.	• One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to age 16.
Type C - Major Restorative How Many/How Often		
Implants	• One per tooth position in 5 calendar years	• One per tooth position in 5 calendar years
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. • Dentures and bridgework replacement: one every 5 years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. • Dentures and bridgework replacement: one every 5 years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Crowns/Inlays/Onlays	• Replacement: once every 5 years.	• Replacement: once every 5 years.
Type D – Orthodontia How Many/How Often		
	• Your Children, up to age 26, are covered while Dental Insurance is in effect All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.	• Your Children, up to age 26, are covered while Dental Insurance is in effect. All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.

The service categories and plan limitations shown above represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

MetLife

www.metlife.com/mybenefits

Learn more about your MetLife benefits

MetLife benefits information right from your desktop

The MyBenefits web site is a quick and easy way for you to get the information you need about your MetLife benefits – all in one place. Log in at **www.metlife.com/mybenefits** to see how we've taken personalization and integration to a new level.

Personalized homepage to all your MetLife benefits

Get more information on your MetLife benefits and access helpful tools from your personalized homepage.

Dental plans – Easily find a participating dentist or view your benefits, copay or coinsurance amount, and claims* online. Plus, look up the average costs for in-and out-of-network services* or link to www.oralhealthlibrary.com to research important dental topics.

Dental ID cards are available online for you to download and print at your convenience. Cards contain your name, employer's name and group number. Also included are MetLife's claims submission address,* website address, customer service telephone number and a service number for International Dental Travel Assistance*.

Additional MyBenefits features include:

- Planning tools that you can use to help you make informed decisions regarding your retirement benefits coverage as well as other useful information for a variety of everyday topics.
- Forms and documents that you may need are located in the forms library for you to download.
- In the "News & Updates" section you'll find information from MetLife and your employer such as enrollment dates and new product offerings.
- Online claims tracking and e-mail notifications called eAlerts, which will provide information regarding status changes to your claims for certain benefits.*

The MetLife Mobile App is now available on the iTunes App Store and Google Play. Download the app and use it to find a participating dentist, view your claims* and to see your ID card.[1]

*This feature is not available for members with a MetLife Dental HMO/Managed care plan. Like most group benefit programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitation and terms for keeping them in force. Ask your MetLife group representative for complete details.

1 Before using the MetLife Mobile App, you must register at www.metlife.com/mybenefits from a computer. Registration cannot be done from your mobile device. Certain features of the MetLife Mobile App are not available for all MetLife Dental Plans.

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com

MetLife

www.metlife.com/mybenefits

You Can Benefit from MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information including planning tools and oral health awareness material.* MetLife is able to deliver services that empower you to manage your benefits. As a first time user, you will need to register on MyBenefits, requiring you to follow the steps outlined below.

Registration Process for MyBenefits

Provide Your Group Name

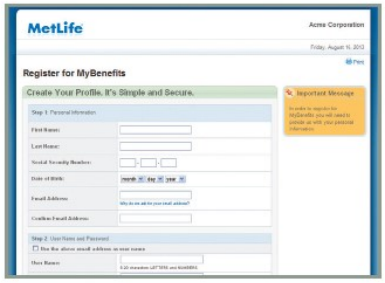
Access MyBenefits at www.metlife.com/mybenefits and enter your group name and click **'Submit.'**

The Login Screen

On the Home Page, you can access general information. To begin accessing personal plan information, click on **'Register Now'** and perform the one-time registration process. Going forward, you will be able to log-in directly.

Step 1: Enter Personal Information

Enter your first and last name, identifying data and e-mail address.



Step 2: Create a User Name and Password

Then you will need to create a unique user name and password for future access to MyBenefits.

The User Name and Password requirements may vary by company setup. General setup includes a User Name between 8-20 characters, containing at least one letter and one number, and a password between 6-20 characters, containing at least one letter and one number.

Step 3: Security Verification Questions

Now, you will need to choose and answer three identity verification questions to be utilized in the event you forget your password.

Step 4: Terms of Use

Finally, you will be asked to read and agree to the website's Terms of Use.

Step 5: Process Complete

Now you will be brought to the "Thank You" page.

Lastly, a confirmation of your registration will be sent to the e-mail address you provided during registration.

Available only to dental benefits participants.

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com

VISION BENEFITS

20/20 Eyecare Plan

2900 West Cypress Creek Road, Suite 4, Fort Lauderdale, FL 33306

COVERAGE	IN-NETWORK PLAN BENEFIT
Eye Examination:	$4.00 co-pay. One exam per 12 months.
Frames:	$10.00 co-pay up to $79 allowance. One per 12 months.
Lenses: (standard lenses in clear glass or plastic) Single Vision: Bifocal: Trifocal: Lenticular:	 $10.00 co-pay $10.00 co-pay $10.00 co-pay $10.00 co-pay
Lens Options: Tint, UV, Scratch Coat, Anti-Reflective, Progressive, Poly carbonate, Hi-index, Photogray, Transitions, Polaroid, etc.	Member pays pre-arranged additional fees per 20/20 Options list.
Contact Lenses: In lieu of Eyeglass Benefit – allowance is for exam, fitting, evaluation, follow-up care and materials.	$100 allowance - $4.00 co-pay
Laser Vision Correction Surgery	**Discount program only** – please call 20/20 for information
Monthly Premium Rates: **Employee Only: $3.91** **Employee + One: $7.79** **Employee + Two or More: $12.24**	

Welcome to Securian

We are pleased to introduce your new group Life Insurance carrier, underwritten by Minnesota Life and administered by Ochs, Inc. Effective October 1st supplemental life will be available for employees AND their families.

Employees, spouses and children will have a **special one-time opportunity to enroll in coverage with no health questions.** See the Guaranteed Issue (GI) amounts below and the full plan details and enrollment options on the following page.

INITIAL ENROLLMENT - Special Guaranteed Issue (GI) Offer

Employees can elect the supplemental life amounts noted below with **no health questions asked** (up to the GI limits). Guaranteed elections will be effective October 1, 2016. Enrolling beyond the GI limit and in the future will require Evidence of Insurability (EOI) and underwriting approval. As an exception, child life will be available GI each annual enrollment period.

GUARANTEED ISSUE AMOUNTS AVAILABLE	
Active Employees (currently enrolled in supplemental life)	Enroll for up to $150,000*
Active Employees (no current supplemental life)	Enroll for up to $50,000
Spouse Life	Enroll for up to $30,000
Child Life (one election covers all eligible children)	Enroll for $10,000
Dependent Life Package (spouse AND child)	Enroll for $10,000 each*

*GI limit includes supplemental coverage currently in force.

Beneficiary Designations

Your employer is requesting that you update your beneficiaries at this time. Please review and make any necessary changes to your beneficiary designations.

Enroll July 28 - August 10, 2016

Please turn in your Evidence of Insurability form for coverage beyond the GI limits to your Human Resources/Risk Management Office **no later than August 10th.**

Questions

Contact Human Resources/Risk Management or Ochs, Inc. M-F 8:00 a.m. to 4:30 p.m. CT.
Email: ochs@ochsinc.com or Phone: 1-800-392-7295

OCHS INC.
A Securian Company

SECURIAN®

City of Ocala

Your Group Life Insurance Benefits

Your employer offers Term Life and Accidental Death and Dismemberment (AD&D) insurance to benefit eligible employees. Coverage is underwritten by Minnesota Life Insurance Company and administered by Ochs, Inc.

BASIC TERM LIFE (employer paid)

Amount

- **Amounts vary according to job classification -** see certificate

Additional Information

- **Employer provided** - no election required
- Includes an AD&D benefit of 1x annual salary plus $10,000
- AD&D benefit terminates at age 70

SUPPLEMENTAL LIFE PROGRAM (employee paid)

Build a stronger financial package to protect your family against the unexpected loss of life and income during your working years.

Through a **Supplemental Term Life Program,** employees can elect additional insurance for themselves, their spouse and their children. Enrolling for employee or spouse supplemental term life will require Evidence of Insurability (EOI) and underwriting approval - except as a new employee or if a qualified family status change occurs, at which time guaranteed issue (GI) coverage is available.

GUARANTEED ISSUE

New Employees

can elect coverage during their 31 day initial enrollment period - without health questions. Evidence of Insurability will be required outside of this opportunity (except for a qualified family status change) and also for elections greater than the **guaranteed amounts** below.

Guaranteed Amounts[1]

- **Employees** - up to $150,000
- **Your spouse** - up to $30,000
- **Your children** - $10,000
- **Dependent Package** - spouse $10,000 and child(ren) $10,000

Coverage	Amount	Additional Information
Employee Supplemental Term Life	• $10,000 increments • Maximum: 5x annual salary, not to exceed $500,000	• Evidence of Insurability is required[1] • New employees - see **Guaranteed Issue** opportunity
Spouse Term Life	• $5,000 increments • Maximum: $250,000 - not to exceed 100% of employee's basic and supplemental total coverage	• Evidence of Insurability is required[1] • New employees - see **Guaranteed Issue** opportunity
Child Term Life	• $10,000	• Elections are **Guaranteed** each annual enrollment • Children are eligible from live birth to age 26 • New employees - see **Guaranteed Issue** opportunity
Dependent Package Term Life	• $10,000 spouse and $10,000 per child	• Evidence of Insurability is required[1] • Children are eligible from live birth to age 26 • New employees - see **Guaranteed Issue** opportunity

[1]GI amounts are available for new employees and for qualified family status changes (i.e. marriage or birth/adoption of a child). Amounts are subject to plan maximums.

Monthly cost per $1,000
Employee and Spouse Term Life

Employee Age*	Rate
<25	$0.063
25-29	$0.075
30-34	$0.100
35-39	$0.113
40-44	$0.150
45-49	$0.263
50-54	$0.463
55-59	$0.763
60-64	$0.938
65-69	$1.638
70-74	$2.575
75**	$2.975

*Spouse rates are based on employees age.
**Rates beyond age 75 are available upon request.
Rates increase with age and are subject to change.

Child Term Life
(one election covers all eligible children)

Coverage	Monthly Cost
$10,000 per child	$1.30

Dependent Package

Coverage	Monthly Cost
$10,000 spouse and $10,000 child(ren)	$4.95

How much life insurance do you need?

Visit LifeBenefits.com/insuranceneeds to use an interactive resource to help estimate the amount of insurance your family

Calculate your cost: *(or see the attached rate chart)*	
Total coverage you need divided by 1,000	$_____
x your rate (from the table above)	$_____
= your monthly premium	$_____

Beneficiary Designations

Naming a beneficiary is an important right of life insurance ownership; this determines who receives the death benefit. It is recommended you review and update your elections periodically.

Your life insurance plan includes features and services at no additional cost, beyond the premiums you pay.

Plan Features

- **Waiver of Premium** - If you become totally and permanently disabled, life insurance premiums may be waived.
- **Accelerated Benefit** - If an insured person becomes terminally ill with a life expectancy of 12 months or less, he/she may request early payment of up to 100% of the life insurance amount in force.
- **Accidental Death and Dismemberment (AD&D)** - Provides additional financial protection if death or dismemberment results from a covered accident, whether it occurs at work or elsewhere.
- **Portability -** If you are no longer eligible for group coverage, you have 31 days to port your group life insurance. Portable coverage ends at age 70. Premiums may be higher than those paid by active employees.
- **Conversion -** If you are no longer eligible for group coverage or your portability period is ending, you have 31 days to convert this coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

LifeSuite Services

- **Travel Assistance** - Access to 24/7/365 emergency travel assistance services provided by RedpointWTP LLC. More information is available at lifebenefits.com/travel, or by calling 1-855-516-5433.
- **Legal, Financial and Grief Counseling** - Services such as drafting legal documents and consultations are provided by Ceridian HCM, Inc. Additional information is available at lifeworks.com: Username: **lfg**, Password: **resources,** or by calling 1-877-849-6034.
- **Legacy Planning** - Active and retired employees and their families can access resources to help work through end-of-life issues or plan a funeral. Visit: LegacyPlanningResources.com.
- **Beneficiary Financial Counseling** - Beneficiaries who receive at least $25,000 in policy benefits may choose to use independent beneficiary counseling services from PricewaterhouseCoopers LLP.

For more information about LifeSuite Services visit:
brainshark.com/securian/LifeSuiteServices

Convenient Payroll Deductions

- Premiums are automatically deducted from your paycheck.

Questions

Contact Human Resources/Risk Management or Ochs, Inc. M-F 8:00 a.m. to 4:30 p.m. CT (**Phone:** 1-800-392-7295 or **Email:** ochs@ochsinc.com). A representative is available to help you.

Take Action - Enroll Now

Don't miss this enrollment opportunity!

Turn forms in to:
Human Resources/Risk Management

Ochs, Inc.
A Securian Company

400 Robert Street North, Suite 1880, St. Paul, MN 55101
ochs@ochsinc.com • 651-665-3789 • 1-800-392-7295
ochsinc.com

Rev. 07-2016

Supplemental Life Insurance
Plan Highlights and Guaranteed Issue Offer

Effective October 1, 2016

Guaranteed Issue - NO HEALTH QUESTIONS - during your initial enrollment period (July 28 - August 10, 2016)

Employees: Enroll for up to $150,000

Spouses: Enroll for up to $30,000

Children: Enroll for $10,000

Dependent Package: Enroll for $10,000 for your spouse and $10,000 for your child(ren)

- Employees enroll for up to the lesser of 5x annual salary or $500,000
- Spouses enroll for up to $250,000 (not to exceed employee's total basic and supplemental life amount)
- Children enroll for $10,000
- Enroll in a Dependent Package - $10,000 spouse / $10,000 child(ren)

- Child Life is available guaranteed issue each annual enrollment
- One election covers all children from live birth to age 26 - regardless of student, marriage, or financial dependency status

- Spouse coverage is allowed, even if the employee does not elect supplemental life

- Portability of coverage is available if you leave or retire from the City

- All employees covered under the employer paid, basic life benefit are eligible for **LifeSuite Services at no additional cost:**
  Legal , Financial and Grief Counseling; Travel Assistance; Legacy Planning; and Beneficiary Counseling

VOLUNTARY LONG TERM DISABILITY

MetLife

What is Long-Term Disability Insurance?

Long-Term Disability (LTD) insurance can help replace a portion of your income if you are unable to work for an extended period of time due to sickness or accidental injury. It helps to provide the day to day peace of mind that comes from knowing that, during the time you would be recovering from a significant event in your life, you may not have to shoulder the additional burden of wondering how you're going to pay for the things that would still have to be paid for.

Why Should I Consider LTD Insurance?

You may have already purchased home, auto and life insurance to protect yourself against the threat of loss. And, you may already have health insurance to protect you against the cost of medical bills. But, have you protected one of your most valuable assets—your ability to work and earn a living?

Your employer recognizes the need for you to protect your ability to earn an income and is offering you the opportunity to enroll in Long term Disability insurance coverage from MetLife. The plan is being made available to you with the convenience of payroll deduction so you don't have to worry about mailing monthly payments.

Eligibility Requirements and Rates:

All active full-time **Police, Fire and EMT Employees** working at least 40 hours per week are eligible to participate and the rates are listed as **EMERGENCY PERSONNEL**.
All **Active full-time employees, exclusive of Policy, Fire and EMT,** employees working at least 40 hours per week are eligible to participate and the rates are listed as **NON EMERGENCY PERSONNEL**.
Rates are on the following page. Please refer to the correct chart for your classification as an Emergency Personnel or Non-Emergency Personnel.

How is "Disability" Defined Under the Plan?

Generally you are considered disabled and eligible for long term benefits if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and complying with the requirements of the treatment and you are unable to earn more than 60% of your pre-disability earnings from any employer in your local economy at any gainful occupation for which you are reasonably qualified taking into account your training, education and experience.

What is the benefit amount?

The benefit amount is 60% for your pre-disability earnings up to a maximum of $10,000.

When do benefits begin and how long do they continue?

Benefits begin after the end of the elimination period (EP).
The elimination period begins on the day you become disabled and is the length of time you must wait, while disabled, before you are eligible go receive a benefit. The elimination period is determined by your election. You may choose from 30,60,90,or 180 days towards the elimination period.

For a complete description of this and other requirements that must be met, and additional disability plan benefits, refer to MetLife's Certificate of Coverage provided by The City of Ocala.

Monthly Premiums for Long Term Disability

1. To determine your premium, refer to the chart below (**either** emergency personnel **or** non-emergency personnel) for the rates per $100 of covered monthly salary, then select your age banded rate.

LTD Rates for Emergency Personnel ONLY (Police, Fire, EMT)								
Elimination Period:	**Employee's Age**							
	Under 35	35-39	40-44	45-49	50-54	55-59	60-64	65+
30 day EP	0.887	1.836	3.611	4.779	5.202	5.229	5.048	3.411
60 day EP	0.485	1.004	1.974	2.612	2.843	2.858	2.759	1.864
90 day EP	0.217	0.450	0.885	1.170	1.274	1.281	1.236	0.836
180 day EP	0.131	0.272	0.535	0.708	0.771	0.775	0.748	0.506

LTD Rates for NON—Emergency personnel (Excludes Police, Fire, EMT)								
Elimination Period:	**Employee's Age**							
	Under 35	35-39	40-44	45-49	50-54	55-59	60-64	65+
30 day EP	0.595	1.232	2.423	3.206	3.489	3.508	3.386	2.288
60 day EP	0.415	0.860	1.690	2.237	2.435	2.447	2.363	1.597
90 day EP	0.292	0.605	1.191	1.575	1.715	1.724	1.664	1.125
180 day EP	0.192	0.398	0.783	1.036	1.128	1.134	1.095	0.740

2. Complete the following premium calculation worksheet:

Monthly Premium Calculation Worksheet:	
A. Annual Earnings = ***PLEASE NOTE:*** *If your annual earnings exceed $200,000, the premium is based on $200,000, due to the maximum benefit cap. Use $200,000 in this calculation.*	$
B. Monthly Earnings = *("A" divided by 12)*	$
C. Your Monthly Earnings divided by 100 = *("B" divided by 100)*	$
D. Estimated Monthly Premium you will pay = *("C" multiplied by the applicable age-banded rate)*	$

Premiums are based on your current age as of the effective date of coverage. **At each policy anniversary, future costs will change as your age increases.** Premiums also increase if you have increases in salary during the year.
Due to rounding, your actual payroll deducted premium amount may vary slightly.

Long Term Disability Frequently Asked Questions:

Q. Are my benefits taxable?

Since you pay your premiums with after-tax dollars, your benefit in the event of an approved disability is tax free.

Q. Can I return to work part-time and still receive a benefit?

Yes. As long as you are disabled and meet the terms of your disability plan, you may qualify for adjusted disability benefits. Your plan offers financial and rehabilitation incentives designed to help you return to work, even on a part-time basis when you participate in an approved Rehabilitation Program. While disabled, you may receive up to 100% of your pre-disability earnings when combining benefits, Rehabilitation Incentives, other income sources such as Social Security Disability Benefits and part-time earnings. With the **Rehabilitation Incentive** you can get a 10% increase in your monthly benefit. You may be eligible for the **Moving Expense Incentive** if you incur expenses in order to move to a new residence recommended as a part of the Rehabilitation Program. Expenses must be approved in advance. The **Family Care Incentive** provides reimbursement up to $400 per month for eligible expenses, such as child care, during the first 24 months of disability.

Q. If I didn't purchase coverage at a prior date, can I still purchase coverage during open enrollment?

Yes; however, you must complete an Evidence of Insurability Form to apply for coverage. Coverage is not guaranteed and is subject to approval by the insurance carrier.

FLEXIBLE SPENDING ACCOUNTS

The TASC FlexSystem

MEDICAL FLEXIBLE SPENDING ACCOUNT
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

How FlexSystem Works—FlexSystem FSA is administered by TASC (Total Administrative Services Corporation). When you choose to enroll in the Healthcare (Medical) and /or Dependent Care FSA, you choose the dollar amount you want to contribute to each account based on your estimated expenses for the upcoming plan year. Employee salary deductions to the medical FSA are limited to $2,550 and for the dependent care FSA are limited to $5,000 for the plan year. These are taken out on a pre-tax basis from your paycheck.

Enrollment is only during the annual open enrollment.
The TASC DEBIT/VISA Card does not have an annual fee.

Reimbursement and the TASC Card - As you incur eligible expenses, simply swipe your TASC Card. The card automatically pays for and substantiates most eligible expenses at the point of purchase. If you do not use the TASC Card to pay for an eligible expense simply submit a request for reimbursement via one of the following: the My TASC Mobile App, online Request for Reimbursement Wizard in MyTASC, text message, fax or mail.

Your reimbursement is deposited in your MyCash account. You can access your MyCash funds in three ways: (1) swipe your TASC Card at any merchant that accepts major credit cards,
(2) withdraw at an ATM using your TASC Card (with PIN), or
(3) transfer to a personal bank account from MyCash Manager within MyTASC.

You may also call TASC at 1-800-422-4661 and provide your personal bank routing number and account number to authorize TASC to directly reimburse into your personal bank account. This feature is also available online with a one time set-up through MyCash Manager.

Multiple Methods for Account Management -You may use any of the following self-service options to access your FlexSystem accounts and TASC Card transactions:

- **MyTASC Online**: www.tasconline.com
- **MyCash Manager**: within MyTASC at www.tasconline.com
- **MyTASC Mobile App**: free download at www.tasconline.com/mobile
- **MyTASC Text Messaging** : elect through your MyTASC account online

Medical FSA $500 Carryover
It is important to be conservative in making elections because any unused funds left in your FSA at at the close of the Plan Year are not refundable to you. The exception is a $500 carryover which is now available starting with the 2014-2015 Plan Year. You may carryover up to $500 from year to year with no cost or penalty.

Please visit www.tasconline.com for questions on TASC Card issuance, Card Funding, Account Management, Using Your TASC Card, Fees , and Card Operations.

Note: For a list of FSA qualified medical expenses, please visit www.irs.gov/publications/p502

DEPENDENT CARE FSA

The TASC dependent care flexible spending account allows you to have **money deducted** from your paycheck **before taxes** and placed in your MyCash account. Please refer to the proceeding page on Cash Management options and reimbursement. ***After you have accumulated the necessary funds in your dependent care account, you will be reimbursed for dependent care expenses (daycare, extended day, senior care).***
Enrollment is only during the annual open enrollment period.

Special Rules - 3 Important Rules Apply To Flexible Spending Accounts:

1. The status change rule:
Once enrolled you can only change your deduction during the plan year (October 1—September 30) if you have a family status change event and make the request within 30 days of the event.

2. Front end load on the Medical spending account:
Unlike the dependent care FSA, this feature is unique to the healthcare (medical) spending account. The amount you choose to contribute to your medical spending account for the plan year, will be "front loaded" at the beginning of the plan year. ***This means you will be reimbursed up to your annual amount at any time during the plan year regardless of the actual balance in your medical spending account (not to exceed your annual amount).***

For example: If you elect $520.00 for the year and two months into the plan year you have an eligible expense of $520.00, you have access to the total $520.00 even though you have only contributed for two months and have $80.00 in your account. Your account will show a negative balance which you will pay back each pay period from the deductions to your account. This rule does not apply to the Dependent Care account where you may
only be reimbursed up to your actual account balance.

3. *The use it or lose it rule*:
Only allocate funds you know you and your dependents will spend. Any unused amounts in your account at the end of the plan year, except the $500 carryover in the medical FSA, are forfeited to The City of Ocala.
Please see the preceding page on the $500 carryover.

Choose a pet health plan to fit your needs

Prices include 5% discount!

From VPI®, the #1 choice in America for pet insurance

	Major Medical Plan comprehensive℠ + wellness coverage $19/paycheck*	Major Medical Plan comprehensive℠ $13/paycheck*	Pet Wellness Basics everyday care‡ $9/paycheck*
Use any vet	✓	✓	✓
Accidents, including poisonings, cuts and broken bones	✓	✓	
Common illnesses, including ear infections, rashes, vomiting and diarrhea	✓	✓	
Serious/chronic illnesses†, including cancer, diabetes and allergies	✓	✓	
Hereditary conditions‡	✓	✓	
Procedures/services, including surgeries, Rx meds and hospitalization	✓	✓	
X-rays	✓	✓	✓◊
Wellness services, including exams, vaccinations and flea/heartworm preventives	✓		✓
Annual deductible	$250 for medical claims $0 for wellness claims	$250	$0
Max annual benefit	**$14,250**	**$14,000**	**$350**

How does VPI work?

1. Visit any vet.
2. Submit a claim.
3. Receive reimbursement.

That's it!

Chronic conditions? Covered.

Every year, Benny the pug gets a stubborn ear infection. And every year his mom, Julie, rests easy because she's **covered by VPI**.

This year, it took **three vet visits** and **$441** to clear up Benny's ear. Since Julie had met her annual deductible on a previous visit, **VPI sent her a check for the full $441**.

Get your discount today

877-Pets-VPI • www.petinsurance.com/ocalafl

*Per-paycheck pricing is based on a 26 pay period per year cycle. Your pricing may vary depending on your employer's payment schedule. Premiums vary based on the age of the pet, species, size (as an adult), plan type and state of residence. † New illnesses only. Does not include conditions pre-existing to enrollment. ‡ Limited hereditary condition coverage after the first year of enrollment. ◊ Testing benefit includes coverage for one of the following tests per year: health screen (blood test), X-rays or EKG (electrocardiogram).

Veterinary Pet Insurance℠
a Nationwide Insurance® company

THE EMPLOYEE HEALTH & WELLNESS CENTER

2100 NE 30th Ave, Bldg 300 Suite 102.

They are open by appointment:

Monday 7am-5pm (closed for lunch 12pm-1pm)
Tuesday & Wednesday 7am to 6pm (closed for lunch 12pm-1pm)
Thursday 7am-5pm (closed for lunch 12pm-1pm)
Friday 8am-5pm (closed for lunch 12pm-1pm)

CareHere!

Registration & Appointment Scheduler Instructions For
City of Ocala

Minimum Requirements: *Internet Explorer 5.0 (and higher), AOL 7.0 (and higher). If you are unable to view the calendar after login, please call CareHere at 877-423-1330 for scheduling assistance.*

Email addresses are required to register. If you do not have an email address, please call CareHere at 877-423-1330 for scheduling assistance.

New Users - First Time Registration

Please do not register again if you have already previously registered. However, each eligible dependent must register separately.

1. Use your home or office computer that is connected to the Internet.
2. Start the Internet Explorer browser.
3. Enter www.CareHere.com in the website address box of the Internet Explorer (browser)
4. Click **Members Only**
5. Click **I need to register for the first time with my Access Code.**
6. Beside **First time registration** enter *Access code*:**OCALA3**
7. Click **Go**
8. **Consent** page - Please review the consent form. If you agree, check **I agree**.
9. Identification – Please enter the following
    a. Your Social Security number
    b. Your Birth date
    c. Create a Username for yourself (The system will check to make certain no one else has the same username or password.)
    d. Create a password for yourself
    e. Your email address (a home email address is best since a confirmation email will be sent with login instructions containing your username and password.)
10. **Contact** page – Review all the fields and enter or update the appropriate information.
11. **Health** page – Skip any field for which you do not know the answer.
12. **Email Confirmation** – A confirmation email will be sent to the email address you provided.
13. **Thank you.** You are finished! You may now log in as a Member by clicking the **Go to Login Page** button.

Registration and Appointment scheduling is powered by **MyHealthGuide**

CareHere!

Registered User Login – To Schedule an Appointment

1. Use your home or office computer that is connected to the Internet
2. Start the Internet Explorer browser if not already open.
3. Enter www.CareHere.com in the website address box of the Internet Explorer browser.
4. Click **Members Only**
5. Enter your **username** and **password**.
6. Your Home Page will appear.
7. Click **Appointments** to schedule or change appointments.
    a. Standard clinic days and hours will be displayed.
    b. A Calendar will appear.
8. Click a valid clinic day on the calendar.
9. All appointment "slots" will appear *(available and not available slots)*.
10. Click **Make Appointment** to schedule an appointment on your preferred time slot.
    a. A pop-up screen will appear. (Make sure your computer permits "pop-ups." You may need to adjust the size of the pop-up by clicking on the lower right corner and "dragging" the corner to change the pop-up window size.)
    b. If you desire, enter Symptoms, reason for appointment, or comments.
    c. Click **Print** if you want a printed reminder copy of the appointment.
11. Click **Submit** to save. (The pop-up window will close automatically.)
    a. The Calendar will automatically update and show your scheduled appointment.
    b. You can edit or delete your appointment at any time.
    c. You can only view details about your own appointment. No one else can see that you have a scheduled appointment.

Need Help? Call **CareHere** *877-423-1330* or email medical@carehere.com

CANCER POLICY

Group Voluntary Cancer

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Allstate's cancer insurance can help provide security when you need it most.

Take a look at what Allstate has to offer…

Meeting your needs

Allstate's cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned.
- Coverage can be purchased for you or entire family.
- No evidence of insurability required for newly eligible staff.
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts.
- Includes coverage for 29 other specified diseases.
- Convertible coverage.

Premiums start at

$8.62 per pay period - Employee

$14.76 per pay period - Family

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offers you and your family coverage should you be diagnosed with cancer or 29 other specified diseases. It protects you and your family 24-hours a day, seven days a week, and is easily convertible. Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse and dependent children). Allstate's valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive :

- Benefits that can help pay for treatment, hospital stays, transportation, and much more.
- Easy online enrollment.
- Benefit coverage that includes 29 other specified diseases.

Note: During open enrollment, if you did not previously apply for this coverage, you must fill out a Medical Questionnaire for Allstate approval.

CRITICAL ILLNESS INSURANCE

Allstate
You're in good hands.

Group Voluntary Critical Illness

You can't predict the future, but you can plan for it. We invite you to put yourself in Good Hands with Critical Illness insurance from Allstate Benefits.

Key Features

- GUARANTEED ISSUE during Open Enrollment.
- Coverage available for spouse and children.
- Benefits are paid regardless of any other coverage.
- Premiums are affordable and conveniently payroll deducted.
- Coverage may be continued.
- Annual wellness benefit.

PREMIUMS start at

$1.61 per pay period (employee)
$2.60 per pay period (family

Based on age and tobacco status

Here's How it Works

You select the benefit coverage amount you want based on your individual need and budget. If you have covered family members, our coverage also provides cash benefits to them. If diagnosed with a covered critical illness, you will receive a cash benefit based on the condition.

YOU DECIDE how to use the cash benefits

- Finances – can help protect your savings and retirement plans from being depleted
- Travel – you can use your cash benefits to help pay for travel to receive treatment in another city
- Home – you can use your benefit to help pay mortgage, rent, etc.

Note: During open enrollment, Critical Illness insurance will be offered with GUARANTEED ISSUE (No health questions.)

ACCIDENT INSURANCE

Group Voluntary Accident Plan

Even when you live well, accidents happen. We invite you to put yourself in Good Hands with Accident insurance from Allstate Benefits.

Key Features

- ON and OFF THE JOB coverage.
- GUARANTEED ISSUE during Open Enrollment.
- Coverage available for spouse and children.
- Benefits are paid regardless of any other coverage.
- Premiums are affordable and conveniently payroll deducted.
- Coverage may be continued.
- Annual physician treatment benefits.

PREMIUMS start at

$7.26 per pay period (employee)
$18.48 per pay period (family)

All employees pay the same price.

Here's How it Works

Our coverage pays cash benefits for a variety of occurrences, such as fracture, dislocation, hospital confinement and more due to an accident. The cash benefits are payable directly to you.

YOU DECIDE how to use the cash benefits

- Finances – can help protect your savings and retirement plans from being depleted
- Travel – you can use your cash benefits to help pay for travel to receive treatment in another city
- Home – you can use your benefit to help pay mortgage, rent, etc.

Note: During open enrollment, GUARANTEED ISSUE (No health questions.)

U.S. LEGAL SERVICES
EST 1974

Finally… a legal benefit plan that works the way you expect it to… one that actually pays your attorneys' fees! With the **Family Defender, you and your family** (dependents up to age 18, or under age 25 as long as enrolled in an accredited college/university full time) are covered for all your personal legal needs. It's like having your own "Attorney on Retainer", 24 hours a day, 7 days a week!

Family Defender *What this plan covers (including but not limited to)*	***Average Attorney's Fees Without Plan***	***Average Attorney's Fees With Plan***
• Legal Consultations in the office or over the phone	$50 to $250	$ 0
• Wills: Preparation & Review	$50 to $3,500	$ 0
• Document Preparation & Review	$50 to $1,500	$ 0
• Lawsuits as Plaintiff or Defendant	$2,500 to $75,000+	$ 0
• Traffic Violations	$125 to $750	$ 0
• Purchase or Sale of your home	$250 to $1,200	$ 0
• Landlord/Tenant Law	$100 to $3,500	$ 0
• Probate of Will	$1,500 to $12,500	$ 0
• Chapter 7 & 13 Bankruptcy	$850 to $5,000+	$ 0
• Juvenile Law	$1,500 to $5,500+	$ 0
• Criminal Law	$1,200 to $5,000+	$ 0
• First Offense DUI	$1,500 to $5,000+	$ 0
• Divorce *(limitations may apply)*	$500 to $50,000	$ 0
• Annulment	$750 to $3,500	$ 0
• Child Support *(limitations may apply)*	$500 to $2,500	$ 0
• Child Custody *(limitations may apply)*	$750 to $25,000	$ 0
• Adoptions	$1,000 to $3,500	$ 0
• Consumer Law	$50 to $7,500	$ 0
• Immigration	$500 to $5,000	$ 0
• Personal Injury	40% +	Reduced Fees

Coverage includes representation up to and through trial, local network of attorneys close to your work or home, 24/7 Customer Service, 24/7 Emergency Services in the event of arrest, Online Will and other Document Preparation, and Online Legal Library. *Some limitations apply. 15 hour annual renewable cap on family law.*

Family Defender $16.90 per month

For more information, please contact:
Dixie Kuehn, Agent for U.S. Legal Services
Office: 321-799-2986 Cell: 321-403-0156 Email: DixieKuehn@cfl.rr.com
To learn more visit **www.uslegalservices.net** or call **(800) 356-LAWS**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name	4. Employer Identification Number (EIN)	
City of Ocala	59-6000392	
5. Employer Address	6. Employer Phone Number	
110 SE Watula Ave	352-401-3986	
7. City	8. State	9. ZIP Code
Ocala	FL	34471
10. Who can we contact about employee health coverage at this job?		
Ms. Devan Kikendall		
11. Phone Number	12. Email Address	
352-401-3986	dkikendall@ocalafl.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐All employees.
  ☒Some employees. Eligible employees are working 30 or more hours per week.

- With respect to dependents:

  ☒We do offer coverage. Eligible dependents are: a spouse of the employee, a natural child, a stepchild, a legally adopted child, a child for whom legal guardian ship has been awarded to the employee or spouse, the newborn child of an enrolled dependent until the newborn reaches 18 months of age.

  ☐We do not offer coverage.

☒If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)

☒ **No** (STOP and return this form to employee)

14. **Does the employer offer a health plan that meets the minimum value standard*?**

☒ **Yes** (Go to question 15) ☐ **No** (Stop and return this form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan per month?
_____$20_____

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums per month for that plan? $_____

Date of Change: _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986

Important Notice from City of Ocala about Your Prescription Drug Coverage and Medicare - For Florida Blue's 03359 Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Ocala and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **City of Ocala has determined that the prescription drug coverage offered by Florida Blue is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

OMB 0938-0990

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Ocala coverage will be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits.

Florida Blue administers the group health coverage available to City of Ocala employees, retirees and dependents. The included prescription drug benefit provides:

	Network	Non-Network	Mail Order
Tier 1	**$10**	**50% Coinsurance**	**$20**
Tier 2	**$100 Deductible + $30**	**$100 Deductible + 50% Coinsurance**	**$100 Deductible + $60**
Tier 3	**$100 Deductible + $45**	**$100 Deductible + 50% Coinsurance**	**$100 Deductible + $90**

If you do decide to join a Medicare drug plan and drop your current City of Ocala coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with City of Ocala and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Ocala changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC **Updated April 1, 2011**

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	07/07/2016
Name of Entity/Sender:	City of Ocala
Contact--Position/Office:	Ms. Devan Kikendall
Address:	110 SE Watula Ave Ocala, Fl 34471
Phone Number:	352-401-3986

Important Notice from City of Ocala about Your Prescription Drug Coverage and Medicare - For Florida Blue's 05902 Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Ocala and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **City of Ocala has determined that the prescription drug coverage offered by Florida Blue is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

OMB 0938-09

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Ocala coverage will be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits.

Florida Blue administers the group health coverage available to City of Ocala employees, retirees and dependents. The included prescription drug benefit provides:

	Network	Non-Network	Mail Order
Tier 1	**$20**	**50% Coinsurance**	**$40**
Tier 2	**$200 Deductible + $40**	**$200 Deductible + 50% Coinsurance**	**$200 Deductible + $80**
Tier 3	**$200 Deductible + $60**	**$200 Deductible + 50% Coinsurance**	**$200 Deductible + $120**

If you do decide to join a Medicare drug plan and drop your current City of Ocala coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with City of Ocala and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Ocala changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC **Updated April 1, 2011**

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	07/07/2016
Name of Entity/Sender:	City of Ocala
Contact--Position/Office:	Ms. Devan Kikendall
Address:	110 SE Watula Ave Ocala, Fl 34471
Phone Number:	352-401-3986

CMS Form 10182-CC Updated April 1, 2011

IMPORTANT NOTICES FOR PLAN PARTICIPANTS

HIPAA Special Enrollment Rights – If you are declining enrollment for yourself or your dependents (including you spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In additional, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
Effective April 1, 2009, a special enrollment period provision is added to comply with the requirements of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. If you or a dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after the date eligibility is lost. If you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after you or your dependent is determined to be eligible for State premium assistance.
Please note that premium assistance is not available in all states.

Medicaid and the Children's Health Insurance Program - If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.
Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is a called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

Michelle's Law – The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. This law applies to medically necessary leaves of absence that begin on or after January 1, 2010.
If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).
Your employer will require a written certification from the child's physician that states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

IMPORTANT NOTICES FOR PLAN PARTICIPANTS

Section 111 – Effective January 1, 2009 Group Health Plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help establish who pays first. The mandate requires Group Health Plans to collect additional information, more specifically Social Security Numbers for all enrollees, including dependents six months of age or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

Women's Health and Cancer Rights Act of 1998 – The medical plans provide benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy, including lymph edema.

Important Notice About Your Prescription Drug Coverage and Medicare – This notice has information about current prescription drug coverage with City of Ocala. and about options under Medicare's Part D prescription drug coverage. The information can help individuals eligible for Part D decide whether or not to join a Medicare drug plan. Prior to November 15th, a Medicare Part D Notice will be mailed to your home providing details and creditable coverage information.

Notice of Privacy Practices—This notice describes the medical information practices of all the group health plans (collectively, the "Plan") maintained by City of Ocala. (the "Plan Sponsor") and that of any third party that assists in the administration of Plan claims. The Plan has been amended to incorporate the requirements of this notice. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the use and disclosure of your medical information created in the doctor's office or health provider's facility. This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

Notes

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.

Company Name	Customer Service	Website
Brown & Brown PRIA Public Risk Insurance Agency	Francene Marra (386) 239-5769 Robin Riley (386) 239-4051	www.bbpria.com
Florida Blue In the pursuit of health	Medical 877-352-2583	www.bcbsfl.com
MetLife	Dental : 800-438-6388 Disability: 800-858-6506	www.metlife.com
2020	Vision 800-525-9778	www.2020eyecareplan.com
OCALA	HR & Risk Management	352-629-8359
Veterinary Pet Insurance VPI a Nationwide Insurance company	Pet Insurance 877-738-7874	www.petinsurance.com/ocalafl
TASC	Flexible Spending Account 800-422-4661	www.tasconline.com
Allstate	Allstate Cancer, Accident and Critical Illness	Tom Watson 352-237-0452
U.S. Legal Services	Legal Services	Dixie Kuehn 321-799-2986
MINNESOTA LIFE A Securian Company	Life Insurance 1-800-392-7295	www.ochsinc.com