Punta Gorda

Florida's Harborside Hometown

2021-2022 Benefit Guide

October 1, 2021 through September 30, 2022

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 23 for more details.

Table of Contents

COVID-19 Disclaimer

In response to the COVID-19 pandemic, Congress enacted legislation to provide temporary relief and greater access to health care services and treatment. This temporary relief included such things as requiring insurers and plans to cover COVID-19 testing with no cost share to the employee; and expanding virtual health care service by easing the rules regarding telehealth. Since those changes were implemented for a limited period of time, this Benefit Guide represents your employee benefit offerings without regard to any temporary COVID-19 relief. For changes that occurred due to COVID-19, please refer to the COVID-19 information provided by your employer.

Introduction

We understand that your benefits are important to you and your family, and helping you understand the benefits available to you is essential. This Benefit Guide provides a description of our benefit program and summary explanations of the benefits, which include:

» Medical Insurance. Three options: BlueCare 55, BlueChoice 0727, BlueOptions 05901
» Dental Insurance. High DPPO
» Vision Insurance. Paid for by you.
» Basic Life and Accidental Death & Dismemberment Insurance for you. Paid for by us.
» Basic Life Insurance for your spouse and/or child. Paid for by you.
» Voluntary Life Insurance for you, your spouse and/or child. Paid for by you.

You are eligible to participate in our insurance plans if you are a full-time employee. If you are a new employee, you will have a 30-day waiting period, and your benefits will begin on the 1st of the next month following the waiting period.

This Guide is not intended to cover all provisions of all plans, but rather to give you a quick reference to help answer most of your questions. Please see the carrier benefit summaries and certificates for more details.

Contact Information

For	You Should Contact	How to Contact Them
» Address and beneficiary changes » Eligibility questions » Whether particular services are covered by the benefit plan » Qualifying Event Notifications, such as marriage, birth, divorce, death, child becoming ineligible	» Human Resources	» Jeff Payne HR Manager 941.575.3371 jpayne@cityofpuntagordafl.com
» Medical plan claims questions » Medical provider network questions » Prior authorization » Appeals	» Florida Blue	» 800.664.5295 / www.FloridaBlue.com
» Non-emergency medical care, such as cold and flu symptoms, sinus issues, UTI, respiratory infections	» Teladoc	» 800.835.2362 / Teladoc.com
» Other non-emergency medical care	» Convenient Care Center or Urgent Care Center	» 800.664.5295 / www.FloridaBlue.com
» Dental plan claims questions » Dental provider network questions	» Florida Combined Life	» 888.223.4892/ www.FloridaBlueDental.com
» Vision plan claims questions » Vision provider network questions	» National Vision Administrators (NVA)	» 800.672.7723 / www.e-nva.com
» Employee Assistance Program support including work-life services and consultations, financial and legal consultations, identity theft support	» Resources for Living	» 800.272.3626/ www.mylifevalues.com Username: PRM Password: 8002723626
» General or specific health concerns or questions	» 24/7 Nurseline - Florida Blue	» 877.789.2583
» Compare medical costs » Managing health conditions	» Care Consultants - Florida Blue	» 888.476.2227

Benefits Eligibility

If you are an eligible employee, there are three occasions on which you can enroll in benefits:

» As a New Hire, after satisfying a waiting period

» Annually during Open Enrollment

» Within 30 days of a Qualifying Event (explained later in this Guide).

During annual Open Enrollment, you will need to make sure that your elections for the next plan year accurately reflect your desired coverage.

Dependent Eligibility

A dependent is defined to include your legal spouse, your dependent child, or a dependent child of your legal spouse.

Dependent children will be covered for medical, dental and vision insurance through the end of the calendar year in which they turn age 26. For medical, dental, and vision insurance, the child may be covered until the end of the calendar year in which they attain age 30 if they meet the Overage Dependent requirements described below.*

A dependent child is defined as:

» A natural born child

» A stepchild

» A legally adopted child

» A child placed in your home for adoption

» A child placed in your home for foster care

» A child for whom legal guardianship or custody has been awarded to you by a court

» An unmarried child of any age who became mentally or physically disabled before reaching the age limit

» A newborn child (up to the age of 18 months) of a covered dependent

*Overage Dependents. Under Florida Statute §627.6562, medical insurance coverage can be continued for children through the end of the calendar year in which they reach age 30 if the child is:

» Unmarried with no dependents; and

» A Florida resident, or a full-time or part-time student; and

» Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

You will be required to sign and submit an Overage Dependent Verification form to Human Resources annually in order to keep your overage dependent child covered under our medical, dental and vision benefits.

Note: The Internal Revenue Code contains provisions that, if met, allow an employer to withhold premiums from your wages on a pre-tax basis to pay for certain insurances you elect. You should consult your tax advisor prior making any elections to have premium dollars withheld from your wages on a pre-tax basis.

Qualifying Events

Coverage elections made during Open Enrollment may not be changed until the next annual Open Enrollment period. The only exception is if there's a Qualifying Event that is allowable under Internal Revenue Code Section 125 and permitted by our Section 125 plan. If you experience a Qualifying Event that affects your eligibility for coverage under our health plan, then you are allowed to make changes to your benefit elections if you notify us within 30 days of the Qualifying Event. If you fail to notify us within the 30 day period, you will not be able to change your benefit elections until the next annual Open Enrollment.

Examples of Qualifying Events include, but are not limited to:

» Marriage

» Divorce

» Birth, adoption, or gaining legal custody or guardianship of a child

» Involuntary loss of other group health insurance coverage

» Death

If you experience a Qualifying Event, you must notify the Contact shown in the Contacts section of this Benefit Guide within 30 days of the Qualifying Event occurring.

YOUR RESPONSIBILITY:

» Before you enroll, make sure you understand the plans and ask questions if you don't.

» After you enroll, you should always check your first paycheck stub to make sure that the correct amount is being deducted and that all the benefits you elected are included.

» Verify that all beneficiary information is up to date.

Medical Benefits

Administered by Florida Blue

We offer medical plans with custom benefits administered by Florida Blue.

Register on the Florida Blue member site: **www.FloridaBlue.com**, to sign up and log in.

If haven't done so already, follow the next few steps to sign up for a Member Account.

» **Step 1:** Go to **www.FloridaBlue.com** and enter your Member Number (shown on your ID card)

» **Step 2:** Complete all the answers and click Next

» **Step 3:** Choose and type in a User ID

» **Step 4:** Choose and type in a Password, and re-enter Password second time

» **Step 5:** Type 3 different security questions with a corresponding answer. Click Next.

» **Step 6:** Click Continue and be taken to the member website home page

On the FloridaBlue member website you'll find lots of helpful information including Provider Directories; Cost Comparison tools; your claims activity; educational information on various health topics; various discount programs; ability to print an ID card; and lots more.

Summaries of the plans we offer follow.

Medical Benefits

Administered by Florida Blue

We offer you medical coverage that utilizes Florida Blue's network of physicians and facilities. You have the option to choose the benefit plan that best meets the benefit and budgetary needs of you and your family.

Before scheduling an appointment with a physician, you should confirm the provider's current participation status within the Florida Blue provider network.

Important to Know Before Enrolling in an HMO:

- **Under this HMO plan, most Services must be rendered by In-Network Providers in order to be Covered Services. It is your responsibility to ensure that the provider you are using is in the Florida Blue BlueCare network.**
- You must select a Primary Care Physician (PCP) for each covered family member.
- You do not need a referral to see an In-Network Specialist, but make sure any services you are requesting do not require prior authorization.

For more details, including limitations, restrictions and exclusions, please refer to the full Schedule of Benefits for the plan option.

	BlueCare 55 HMO	BlueChoice 0727	
Network Access	In-Network	In-Network	Out-of-Network
Plan Year Deductibles			
Individual	$0	$500 per person	Combined with In-Network
Family	$0	$1,500 per family	
Your Benefit Plan			
Coinsurance (when applicable)	0%	20%	40%
Individual Out-of-Pocket Maximum	$1,500 per person	$1,500 per person	Combined with In-Network
Family Out-of-Pocket Maximum	$3,000 per family	$4,500 per family	
Professional Services			
Primary Care Physician (PCP) Office Visits	$10	$15	40% after deductible
Specialist Office Visits	$10	$15	40% after deductible
Teladoc Visits	$0 visits 1-4 then $10 copay	$0 visits 1-4 then $10 copay	N/A
Preventive Care Visits	$0	$0	40%
Hospital Services			
Inpatient Hospitalization	$250	20% after deductible	$300 PAD, then 40% after deductible
Outpatient Hospitalization	Therapy Services - $5 All other Services - $100	20% after deductible	40% after deductible
Urgent Care Center	$10	$15	$15
Emergency Room	$50	20% after deductible	20% after deductible
Independent Clinical Lab (e.g. Blood Work)	$0	20%	40%
MRI, MRA, CT and PET - Facility	$0	$15	40% after deductible
Pharmacy			
Tier 1	$5	$5	50% of allowance
Tier 2	$25	$35	
Tier 3	$25	$35	
Mail Order Pharmacy (90 days)	$10/$50/$50	$10/$70/$70	

	BlueOptions 05901	
Network Access	In-Network	Out-of-Network
Plan Year Deductibles		
Individual	$2,000 per person	$6,000 per person
Family	N/A per family	N/A per family
Your Benefit Plan		
Coinsurance (when applicable)	50%	50%
Individual Out-of-Pocket Maximum	$6,350 per person	$12,800 per person
Family Out-of-Pocket Maximum	$12,700 per family	$25,600 per family
Professional Services		
Primary Care Physician (PCP) Office Visits	$35	50% after deductible
Specialist Office Visits	$75	50% after deductible
Teladoc Visits	$0 visits 1-4 then $10 copay	N / A
Preventive Care Visits	$0	50%
Hospital Services		
Inpatient Hospitalization	Opt 1 - $2,000 Opt 2 - $3,000	50% after deductible
Outpatient Hospitalization	Therapy Services Opt 1 - $80 Opt 2 - $90 All other Services Opt 1 - $300 Opt 2 - $400	50% after deductible
Urgent Care Center	$75	$75
Emergency Room	50% after deductible	50% after In-Network Deductible
Independent Clinical Lab (e.g. Blood Work)	$0	50% after deductible
MRI, MRA, CT and PET - Facility	$200	50% after deductible
Pharmacy		
Tier 1	$10	50% of allowance
Tier 2	$60	
Tier 3	$100	
Mail Order Pharmacy (90 days)	$30/$180/$300	

Tools and Resources to Help You Make the Best Decisions for your Health and Your Wallet

Log into your www.FloridaBlue.com member website after you've registered to access great tools and resources, some of which are described below.

Care Consultants (888.476.2227). Talking to a Care Consultant can save you time and money — and make important decisions easier. Whether it's your first office visit, or a series of ongoing medical treatments or a new medication, call our Care Consultants first. You'll find out how your benefits work, what factors can affect your costs and which programs are available to assist you. The team can help you plan your next steps and make sure you get the most value from your benefits.

24/7 Nurseline (877.789.2583). Whether you have an immediate health concern, or a general question about your doctor's plan of treatment—the nurseline is always open so you don't have to wait for answers. You'll get answers, plus helpful resources that you can use.

Personal Health Information When You Need It. www.FloridaBlue.com provides personal health information when you need it.

- Review your plan benefits and find out where you stand with your deductible.
- Find a doctor or hospital in your plan's network.
- Compare and estimate your costs for medical care and prescription drugs.
- View claim activity, status and history.
- Create a Personal Health Record so your doctor visits and lab results are all in one secure place.
- Print a paper ID card or request a new member ID card.

Mobile App. Download the Florida Blue Mobile App (free for Android and iPhone) to access health information and tools on the go.

- Get your plan details such as deductibles, HSA balance and claims.
- Get a picture of your member ID card.
- Locate doctors in your plan from wherever you are.
- Compare drug prices on the spot and map the nearest pharmacy.
- Get connected to a person who can help you manage your out-of-pocket costs and find quality care.

Know Before You Go. You have choices when it comes to the cost of your health care.

- Shop, compare and estimate your medical costs.
- The quality and price of medical care can vary depending on where you go for office visits, imaging services, and surgery, including inpatient and outpatient care.
- Compare quality and cost before you go, and then decide what's best for your care.
- Cost estimates are based on your plan and where you stand with your deductible. Your costs are lower after your deductible is met – pay only coinsurance or a copay for in-network services.
- You could save hundreds of dollars, or more on your health care services!

You have three easy ways to compare:

Click: www.FloridaBlue.com to log in/register on MyBlueService. Select Estimate Costs for Medical Services

Call: A Care Consultant at 888.476.2227

Visit: A Florida Blue center near you in person. For locations, go to www.FloridaBlue.com

Choosing the Best Place to Receive Care

Lowest ← Cost and Time → Highest

Teladoc	Convenient Care Clinic	Primary Care Physician	Urgent Care Center	Emergency Room
How to Decide which Site of Service to Visit				
Treat: Minor medical conditions.	Treat: Minor medical concerns	Treat: Routine or preventive; to keep track of medications; or for Specialist referrals	Treat: Conditions that are not life threatening	Treat: Critical injuries or illness needing immediate attention
Staff: Board-certified physicians	Staff: Nurse practitioners and physicians assistants	Staff: Physicians, physicians assistants	Staff: Nurses and physicians	Staff: Physicians and nurses
Location: Contact them from anywhere	Location: Retail store / pharmacy	Location: Varies	Location: Stand-alone facilities or near hospital	Location: Hospitals
Hours: Accessible 24/7	Hours: Often nights / weekends	Hours: Sometimes limited extended hours	Hours: Typically have extended hours	Hours: Open 24/7
Conditions Typically Treated				
Cold and Flu Rashes Sore throats Headaches Stomach aches Fever Allergies Acne Urinary tract infections And more	Cold and Flu Rashes and Skin Conditions Sore throats, ear aches, sinus pain Minor cuts/burns Pregnancy testing Vaccines	General health issues Preventive care Routine checkups Immunization and screenings	Fever / Flu symptoms Minor cuts / sprains / burns / rashes Headache Lower back pain Joint pain Minor respiratory symptoms Urinary tract infections	Sudden numbness or weakness Uncontrolled bleeding Seizure / loss of consciousness Shortness of breath Chest pain Head injury or major trauma Blurry / loss of vision Severe cuts / burns
Your Cost and Time				
Cost: Same as PCP visit	Cost: Same as PCP visit	Cost: Copay, coinsurance, deductible	Cost: Less than ER	Cost: Highest cost
Time: Usually 1 hour or less and no need to leave home or work	Time: No appointment needed	Time: Need appointment but wait times shorter	Time: No appointment needed, but wait times vary	Time: No appointment needed, but wait times may be long

The information presented above reflects pre-COVID-19 pandemic information. Due to COVID-19, some changes to both mandated benefits and delivery of service have been affected.

If a situation seems life threatening, call 911 or go to the nearest Emergency Room.

Telehealth

Administered by Teladoc

Teladoc, Inc. is a telehealth company that uses telephone and videoconferencing technology to provide on-demand remote medical care via mobile devices, the internet, video and phone.

Teladoc gives you and your eligible dependents 24/7/365 access to quality medical care through phone and video consults. Teladoc doctors are U.S. board-certified doctors in Florida (and all 50 states) and average 20 years practice experience.

Teladoc is great when you or a family member:

» Needs care immediately

» Cannot get an appointment with your regular physician soon enough

» Is considering the ER or urgent care center for a non-emergency issue

» Is sick on vacation, a business trip, or away from home in the United States

» Needs short-term prescriptions or refills, when appropriate

Teladoc provides treatment for many conditions including cold and flu symptoms, respiratory infection, sinus problems, bronchitis, allergies, urinary tract infection, skin problems, and more.

Set up your Teladoc account today in just a couple easy steps!

Step 1. Set Up Your Account:

» **Online.** Go to **Teladoc.com** and click "set up account."

» **Mobile app**. Download the app and click "Activate account." Visit **teladoc.com/mobile** to download the app

» **Text.** Send a text that says "Get Started" to **469.844.5637**

» **Phone** (toll free). **Call 1.800.Teladoc (835.2362)** and they will help you register your account

Step 2: Provide Medical History. This provides Teladoc doctors with the information they need to make an accurate diagnosis.

Step 3: Request a Consult. Once your account is set up, request a consult anytime you need care.

Dental Benefits

Administered by Florida Combined Life

We offer dental coverage through Florida Combined Life (FCL). You are not required to select a primary dental provider. Instead, you have the ability to receive services through either Participating or Non-Participating Dentists. Please keep in mind that if you choose to use a Non-Participating Dentist, you will pay a higher coinsurance amount for services and you may be subject to "balance billing" for provider fees that exceed the contracted amount allowed by FCL.

	BlueDental PPO High	
Network Access	In-Network	Out-of-Network
Benefit Maximum / Calendar Year	$3,000	
Individual Deductible	$50	
Family Deductible	$100	
Dental Description		
Preventative Services	No charge	No charge
Basic Services	20% after CYD	20% after CYD
Major Services	50% after CYD	50% after CYD
Procedures		
Routine Office Visits – 9430	No charge	No charge
Teeth Cleaning – 1110	No charge	No charge
Full Mouth / Panoramic X-Rays – 0330	No charge	No charge
Amalgam Fillings – 2140	20% after CYD	20% after CYD
Extraction - Simple Per Tooth – 7140	20% after CYD	20% after CYD
Endodontics – 3330	20% after CYD	20% after CYD
Periodontal Scaling – 4341	20% after CYD	20% after CYD
Full Or Partial Dentures – 5110	50% after CYD	50% after CYD
Crowns – 2752	50% after CYD	50% after CYD
Reimbursement UCR or MAC	Negotiated Fee	UCR
Orthodontia	Child & Adult	
Benefit	50%	
Lifetime Maximum	$1,500	

*CYD = Calendar Year Deductible

Vision Benefits

Insured by National Vision Administrators (NVA)

We offer vision coverage through National Vision Administrators (NVA).

It's important to have regular eye exams to detect diseases like glaucoma, diabetes, hypertension, brain tumors and blindness. The NVA Vision Plan provides benefits for services received by both Participating Providers and Non-Participating Providers. You will typically pay less for services when using a Participating Provider and generally subject to a copay.

When using Non-Participating Providers, you will be responsible for paying 100% of the service/material cost, and will then be reimbursed up to a stated amount depending on the service or material.

	National Vision Administrators, LLC	
	In-Network	Out-of-Network
Eye Care Wellness Copay	$10	–
Eye Exam	No charge after copay	Reimbursed up to $35
Exam for Type 1 or Type 2 Diabetes	Covered 100% after $20 copay	Reimbursed up to $13
Frequency	Once per plan year	
Materials Copay	$15	–
Lenses		
Single Vision	No charge after copay	Reimbursed up to $25
Bifocals	No charge after copay	Reimbursed up to $40
Trifocals	No charge after copay	Reimbursed up to $60
Standard Progressive	No charge after copay	Reimbursed up to $25
Frequency	Once per plan year	
Frames		
Selected Frames	$130 allowance + 20% off overage	Reimbursed up to $50
Frequency	Once every two plan years	
Contacts		
Copay	In lieu of Lenses	
Elective	$130 allowance +10% off overage	Reimbursed up to $130
Medically Necessary Contacts	No charge	Reimbursed up to $210
Frequency	Once per plan year	

Life and Disability Benefits

Insured by The Standard

Basic Term Life

We provide you with a Basic Term Life Insurance benefit at no cost to you. All full-time employees working at least 30 hours per week receive a benefit of $20,000.

Accidental Death & Dismemberment

We provide you with AD&D insurance that will pay in addition to the Basic Term Life insurance benefit if death occurs because of an accident. The AD&D benefit amount equals the Basic Term Life benefit.

Basic Dependent Term Life Insurance

In addition to Basic Term Life and AD&D insurance, we offer you the opportunity to purchase Dependent Term Life Insurance at the following benefit levels:

Spouse Term Life Insurance

» New Hires can purchase voluntary spouse life insurance in a flat amount of $5,000 without having to go through Medical Underwriting.

Dependent Child Term Life Insurance

» Benefit amount for children birth to age 26 years: $2,500.

Voluntary Employee Life Insurance

You can purchase additional life insurance for yourself on a voluntary basis in an amount up to $300,000 but not to exceed 5 times your Annual Earnings. Any amount exceeding $150,000 will be required to go through Medical Underwriting.

Voluntary Spouse Life Insurance

If you purchase Voluntary Life Insurance for yourself, then you can purchase life insurance for your spouse in an amount not to exceed 50% of the Voluntary Life Insurance you purchased for yourself. Amounts exceeding $50,000 require Medical Underwriting.

Voluntary Dependent Child Life Insurance

If you purchase Voluntary Life Insurance for yourself, then you can also purchase life insurance for your child in a flat dollar amount of $10,000.

Note: Voluntary Life Insurance benefits payable to a beneficiary are determined without regard to Basic Term Life Insurance benefits also payable.

Employee Assistance Program (EAP)

Administered by Resources for Living

The EAP provides a variety of counseling, referral and information services. **These services are confidential.** The EAP has counseling available for many problems such as stress, alcohol and drug abuse, and family problems. Those counseling sessions can occur face-to-face, by telephone, or by televideo.

Visit the Resources for Living website at **www.mylifevalues.com**. You can call Resources for Living EAP 24/7 at **800.272.3626** to talk to a licensed behavioral health professional for emotional support. Your EAP provides up to five (5) counseling sessions per issue per year with licensed network.

Work-Life Services:

Consultation, information and assistance with locating resources such as:

» Child care, parenting and adoption

» Summer programs for children

» School and financial aid research

» Care for elderly adults

» Caregiver support

» Special needs

» Pet Care

» Home repair and improvement

» Household services

Legal Services:

A free ½ hour consultation with a participating attorney for each new legal topic (each plan year) related to:

» General, family, criminal law

» Elder law and estate planning

» Divorce

» Wills and other document preparation

» Real estate transactions

» Mediation services

A discount of 25% of the fees for services beyond the initial consultation (excluding flat legal fees, contingency fees and plan mediator services). Services must be related to the employee and eligible household members; employment law is excluded.

Identity Theft Services:

One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Web-based Services:

A customized website which offers a full range of tools and resources on behavioral health and work-life balance topics. Most sections of the website are available in Spanish. Website links include:

» Articles and self-assessments

» Access to work-life service providers

» Stress Resource Center

» Free Online Will and other legal documents

» Live webinars and on-demand library

» Mobile app

» myStrength – a “health club” for your mind

Financial Consultation:

A free ½ hour consultation for each new financial topic (each plan year) related to:

» Budgeting

» Retirement or other financial planning

» Mortgages and refinancing

» Credit and debit issues

» College funding

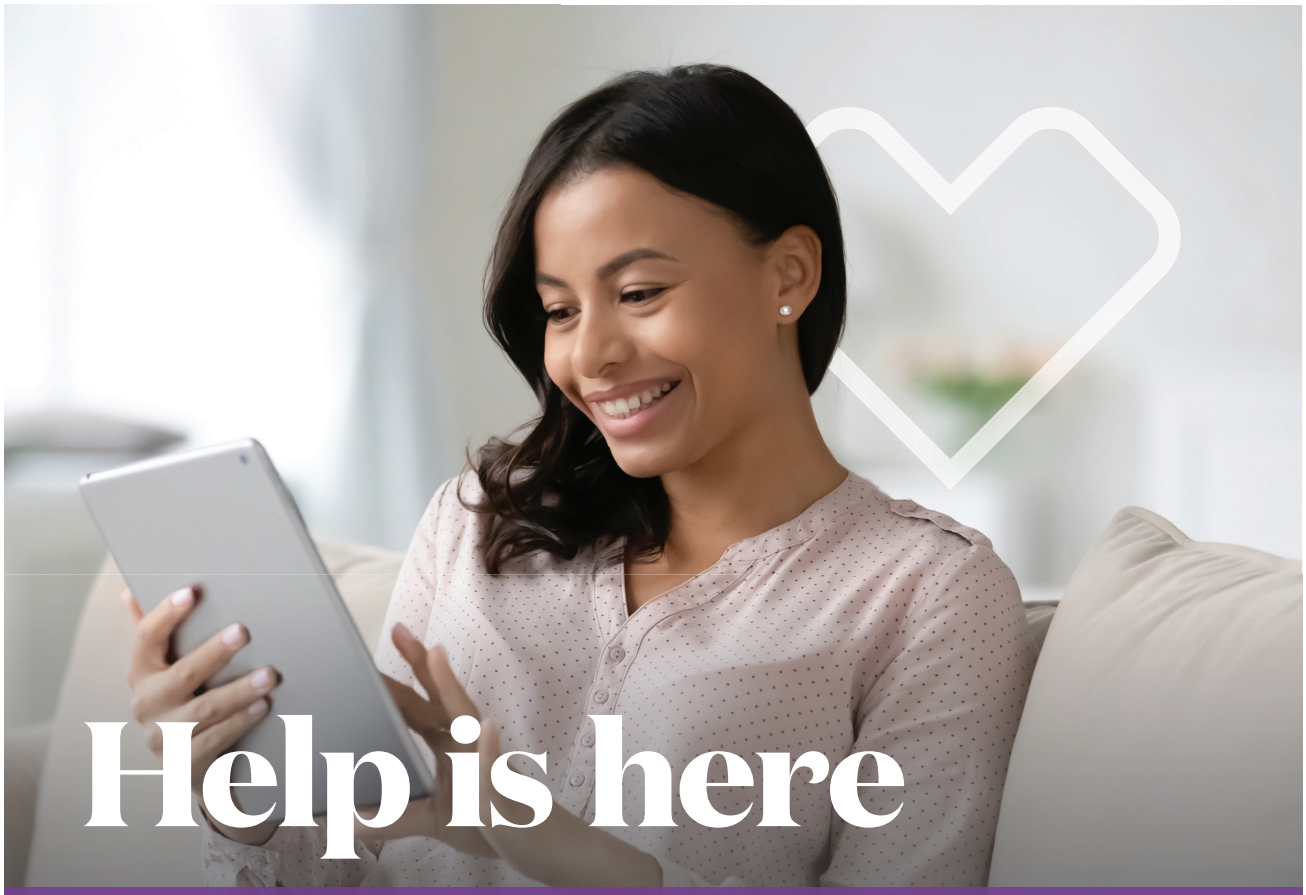
» Tax and IRS questions and preparation

» Discount of 25% tax preparation services

Services must be for financial matters related to the employee and eligible household members.

Discount Center:

The EAP provides discounts on brand-name products and services, including computers and electronics, theme parks, movie tickets, local attractions, travel, gifts, apparel, flowers, jewelry, fitness centers, and more.



Help is here

Welcome to Talkspace

Aetna Resources For Living℠

What is Talkspace?

Talkspace is an online therapy platform that makes it easy and convenient for you to connect with a licensed behavioral therapist — from anywhere, at any time. With Talkspace, you can send unlimited text, video and audio messages to your dedicated therapist via web browser or the Talkspace mobile app. No commutes, appointments or scheduling hassles.

To get started messaging a therapist:

- Login to your member website and go to Services > Talkspace online therapy and select "Sign up for Talkspace".
- Tell us your unique needs and preferences for therapy.
- You'll be shown three potential providers based on your preferences.
- Choose a therapist and begin messaging the very same day.
- Remember: There's no limit to the number of messages you can send your therapist each day.

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After you sign up:

- Use your free sessions: One week of therapy counts as one visit.
- You'll continue to message the same therapist unless you request to change providers.
- Your therapist will reply to you daily, during his or her business hours — five days a week.
- You'll never need to make an appointment or reschedule it because something came up.
- Whether on the go or at home, you can access Talkspace securely via your web browser or mobile app.

Taking care of your mental health can help you live a happier, healthier and more productive life — both on and off the job.

For additional information, please visit our **FAQ**.

Toll-Free Number: 800-272-3626
Website: resourcesforliving.com
Username: PRM Password: 8002723626

*Please note: Chat therapy is for individual counseling for members 13 years of age and older. You have 120 days from the date you sign up to use your sessions. Chat therapy should not be considered for meeting requirements for employment, school enrollment, disability or legal documentation.

Aetna Resources For Living℠ is the brand name used for products and services offered through the Aetna group of subsidiary companies (Aetna). The EAP is administered by Aetna Behavioral Health, LLC. and in California for Knox-Keene plans, Aetna Health of California, Inc. and Health and Human Resources Center, Inc.
All EAP calls are confidential, except as required by law. Talkspace services are provided and managed by Talkspace, Inc., an independent third party. Aetna does not oversee or control the services provided by or recommended by Talkspace and does not assume any liability for their services. EAP instructors, educators and participating providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. For more information about Aetna plans, go to **aetna.com**.

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How To Enroll In Your Benefits During Annual Enrollment

Login

Returning users: Visit www.benefitsolver.com and login using your username and password.

First time users: Register your user name and password and answer a few security questions. The case-sensitive company key is **PRM**. Log in using your new user name and password.

Click on the **Forgot your username or password?** Link to reset your login details.

Explore Your Options

Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

The calendar at the top of the Home page lets you know how many days you have to enroll.

Start Your Enrollment

Click the **Start Here** button to review your personal information and add or edit any dependents you wish to cover.

You will need to provide each dependent's legal name, Social Security Number, and birth date to add them to your coverage. **Note**: You may be required to provide documentation to prove your relationship to each dependent.

Enroll in Coverage

Choose to re-enroll in your current plans, or use the **Next** and **Back** buttons to review and elect options available to you. Choose or decline coverage for each option, and select which family members you want to cover.

Review plan documents and use the **Compare** and **Plan Details** tools to view details and costs for the options available to you.

Review and Finalize Your Elections

Make sure your personal information, elections, dependents, and beneficiaries are accurate, then approve your elections.

To finish, click **I Agree**. When your enrollment is complete, you will receive a confirmation number and can print your **Benefit Summary** for your records.

After You Enroll

Return to the Home page to check for any additional tasks needed to complete your enrollment, view or download your Benefit Summary, and **download the MyChoice Mobile App**.

Reach out to your administrator with questions.

www.benefitsolver.com

Company Key: **PRM**

Annual Disclosures

Model General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

You must provide this notice to:
Jeff Payne
Human Resources
City of Punta Gorda
326 West Marion Avenue
Punta Gorda, Florida 33950
941.575.3371

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa.** (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Jeff Payne
Human Resources
City of Punta Gorda
326 West Marion Avenue
Punta Gorda, Florida 33950
941.575.3371

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the health coverage).

In addition, 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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

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.

Medicare Secondary Payer

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

The Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

Patient Protection: If the Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, 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, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/info-details/masshealth-premium-assistance-pa 800.862.4840
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx 800.692.7462
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820

SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/hipp/ Medicaid: 800.432.5924 CHIP: 855.242.8282
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323,
Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

Medicare D Notice

Important Notice from Your Employer About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with us 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. We have 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 through 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.

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 coverage with us will not be affected.

You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage through us, 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 us 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 will 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 us changes. You may also request a copy of this notice at any time.

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 **800.MEDICARE (800.633.4227)**. TTY users should call **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 **800.772.1213** (TTY **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:	October 1, 2021
Name of Entity/Sender:	City of Punta Gorda
Contact:	Jeff Payne Human Resources
Address:	326 West Marion Avenue Punta Gorda, Florida 33950
Phone Number:	941.575.3371

YOUR RIGHTS UNDER USERRA
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — April 2017

Notes

Notes

Health Trust

The information in this guide is a summary of the benefits available to you and should not be intended to take the place of the official carriers' Member Certificates or our plan's Summary Plan Descriptions (SPD). This guide contains a general description of the benefits to which you and your eligible dependents may be entitled as a full-time employee. This guide does not change or otherwise interpret the terms of the official plan documents. To the extent that any of the information contained in this guide is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases and the plan documents and carrier certificates will prevail.

This guide highlights recent plan design changes and is intended to fully comply with the requirements under federal and state laws as appropriate.

City of Punta Gorda reserves the right, in its sole absolute discretion, to amend, modify or terminate, in whole or part, any or all of the provisions of the benefit plans.

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting

in conjunction with Public Risk Management of Florida Health Trust