CITY OF GAINESVILLE
every path starts with passion
FLORIDA

2018

Retiree Benefits Booklet

Risk Management Department

352-334-5045

Photography Credit:
Suzanna Mars
"In the Name of Science"

RETIREE OPEN ENROLLMENT 2018

What are the changes?	2017	2018
Mental Health Services (outpatient)	• Psychiatrist/Psychologist--$600 CYD & 20% co-insurance • Other Licensed Mental Health Providers--$50 Copay • Primary Care--$15 Copay	• Psychiatrist/Psychologist--$25 Copay • Other Licensed Mental Health Providers--$15 Copay • Primary Care--$15 Copay
Medical Pharmacy (mid-year 2017 change) Does not include allergy injections/immunizations	From January 1-May 31, 2017 • Any Rx administered in office by doctor , members paid 20% of cost of medication up to $50, per med, per month.	From June 1, 2017-December 31, 2017 • Any Rx administered in office by doctor , members pay 20% of cost of medication up to $200, per med, per month.

If you have questions about your bill, coverages or your Medicare coordination of benefits, please contact Florida Blue at 800-664-5295.
The City's plan number is 16035.

If you have questions regarding your prescriptions, please contact Alliance Rx Walgreens Prime at 888-849-7865

If you need to reach the Risk Management Department, please contact our office at 352-334-5045.

Mid-Year Benefit Changes

Qualifying Life Events

Retiree benefit elections must be made during open enrollment. Generally, you may only change your benefits choices during the annual open enrollment period, which is November 1-November 30 each year. However, you can change your applicable benefit plans during the year if you have a qualifying event.

A list of qualifying events follows:

☐ Marriage

☐ Divorce or legal separation

☐ Addition of Certified Dependent

☐ Birth, adoption, or placement for adoption of an eligible child

☐ Death of spouse or covered child

☐ Change in spouse's or certified partner's work status that affects benefits eligibility (e.g., starting a new job, leaving a job, or leave of absence)

☐ A significant change in spouse's or certified partner's health coverage attributable to your spouse's or certified partner's employment (e.g., open enrollment of spouse)

☐ A change in your child's eligibility for benefits

☐ Becoming eligible for Medicare or Medicaid

☐ When making a qualifying event change, you will need to provide proof of the change (e.g., a copy of a marriage license or birth certificate). ***If you do not notify Risk Management within 30 days of the change, you will have to wait until the next annual enrollment period to make benefits changes, unless you have another qualifying event***.

Benefits such as group life insurance are automatic. You do not have to choose them because the City of Gainesville pays the entire cost. The day you retiree, your policy reduces from $50,000 to $25,000. For the next four years, your life benefit is reduced by $5,000 each year. After 5 years, your policy will be valued at $5,000 for the remainder of your life.

Legal Dependents Defined

- A spouse (a husband or wife who is joined in marriage to an retiree by a ceremony recognized by the laws of the Federal Government)
- A natural child or stepchild under age 26 permanently residing with the retiree and supported by the retiree
- A domestic partner (registered with the City of Gainesville)
- A legally adopted child under age 26 or a child, under the age of 26, for whom you have guardianship (permanent or deemed permanent for insurance purposes)
- A child up to the age of 26, unless they have access to their own group coverage, without eligibility rules other than the definition of dependent above. They do not have to be students, or living with you. Repeat, all children up to the age of 26, married or single are now eligible for coverage on their parents' health plan.
- A child 26 years or older who is incapable of self-support due to mental or physical disability; and who has a permanent disability.

Health insurance is the only benefit you are eligible for at Retirement; however, you are able to convert any of your benefits to personal policies when you retire.

Dependent Eligibility By Benefit IF you convert to personal policies at the time of your retirement!!

Health, Dental & Vision

- Legal dependents are eligible to enroll in these benefits until the age of 26 (whether married, a student or residing with the parent/legal guardian).
- Dependents who are over the age of 26, who are physically or mentally unable to work and are supported by the retiree (medical documentation required).
- Grandchildren-Newborns up to 18 months (as long as the parent of the child is covered by the plan).

Supplemental Child Life

- Legal dependents are eligible to enroll in this benefit under the ages of 19. If a full-time student, they may be covered until age 25.

LegalShield

- Never-married dependent children of the retiree or retiree's spouse who are under 21 **and** living at home
- Children under age 18 for whom the retiree or retiree's spouse is the legal guardian
- Full-time never-married students under 23 years old, if the student is a dependent of the retiree or retiree 's spouse
- Any dependent child, regardless of age, who is incapable of sustaining employment because of mental or physical disability and who is chiefly dependent on the retiree or retiree's spouse for support

IDShield

- Dependents under the age of 18
- Dependents between the ages of 18-26 (living at home or a full time student or have never been married are still able to receive credit restoration services.

Dependent Eligibility Documentation Requirements

Dependents	Documentation Required
For Spouse	Copy of marriage certificate. If previously married, death certificate or divorce decree.
For Removal of Spouse/Child	None at Open Enrollment. Court decree within 30 days of decree during the contract year.
For Natural Child(ren)	Child's birth certificate (showing the parent-child Relationship to employee/retiree and/or spouse).
For Adopted Child(ren)	Placement papers signed by the courts.
For Disabled Child (26 years and older)	Physician verification of permanent disability.
Foreign Adoptions	Adoption papers signed by the courts; visa showing date of entry to USA.
For Step-Child(ren)	Child's birth certificate (showing parent-child relationship with employee/retiree's spouse); copy of marriage certificate.
For Court-Ordered Support	State affidavit; copy of signed court order requiring employee/retiree to provide support for health coverage.
For Guardianship	Court ordered guardianship deemed permanent for insurance purposes.
For Domestic Partner	City of Gainesville Domestic Partner Affidavit (notarized within 30 days of approval and only during Open Enrollment
For Termination of Domestic Partner	None at Open Enrollment; City of Gainesville Notice of Termination within 30 days of termination.

Social Security number and date of birth must be provided for all dependents. Failure to submit the dependent's Social Security number will result in termination/denial of coverage. Documentation also applies to life insurance coverage. No documentation is required at Open Enrollment to delete a dependent. All documentation should contain the retiree's name and Social Security number.

Ineligible Dependents

The following are examples of individuals who are not considered eligible dependents: your spouse following a divorce; someone else's child (such as your nieces, or nephews), unless you have been awarded legal custody or guardianship; or parents, parents-in-law, or grandparents, regardless of their IRS dependent status. You must drop coverage for your enrolled dependent within 30 days of the date he or she loses eligibility. For example, if you divorce your spouse or end your domestic partnership relationship, you must contact Risk Management to remove your dependent spouse or domestic partner within 30 days of the divorce or end of domestic partnership. If you fail to remove ineligible dependents, you will be required to pay all costs for any benefits that were paid on their behalf.

Frequently Asked Benefit Questions

Q: There has been a big push for employee/retirees to use Convenient Care Centers and Urgent Care Centers instead of the Emergency Room. What happens if it is during the night and I feel ill?

A: Unfortunately, there are no 24-hour Urgent Care or Convenient Care Centers on the plan. Florida Blue has a 24-hour Nurseline and you can call to speak with a nurse at 1-877-789-2583 to discuss your symptoms and he/she may be able to assist in providing guidance. Remember, the Emergency Room is the gateway to Inpatient hospitalization and it is over-utilized by plan members as a medical home or urgent care.

Q: My daughter is on the plan and is pregnant. Can she remain on the plan as well as the newborn?

A: As long as your daughter remains on the plan (under the age of 26), the newborn may remain on the plan for up to 18 months. Please note, Florida Blue has a toll-free line specifically called Healthy Addition for expectant mothers, especially those with high risk pregnancies. The number is 1-800-955-7635. You may contact someone at this number Monday–Friday, 8:30a-5p.

Q: I went to my pharmacy and under the new plan my copay increased from $50 to $80. Why is that?

A: Our Rx plan has a $300 Rx deductible that applies to Preferred , Non-Preferred and Specialty brand medications. On a quarterly basis, Florida Blue conducts a pharmacy review and updates its formulary. If your copay increased, it may have been due to changes made during this review. Florida Blue posts its changes to the formulary on a quarterly basis, so you are able to retrieve this information at Floridablue.com. You may also contact customer service for questions regarding your pharmacy benefits at 1-800-664-5295.

Q: I went to the doctor for my Wellness Service but I received a bill. I thought the Wellness Services were paid 100% by the City.

A: Wellness Services are determined by your age and gender. If you present for a Wellness Service (please see the Florida Blue Preventive Guidelines-posted on the Risk Management website), the City will pay 100% of the cost associated with the screening. However, if you have other issues that you discuss with your provider that do not relate to the screening, your provider may bill you for that as a separate visit. Please note that these services are diagnosis driven and it is recommended that you start with your Primary Care Physician, if at all possible. If you have questions, please contact FL Blue at 800-664-5295.

Q: I am planning to travel abroad to visit family. What if I get ill while there? Will I be able to access services?

A: Yes. FL Blue has contracted providers in more than 200 countries. If you do plan to travel abroad, the key is to plan ahead by verifying the international benefits prior to leaving. Remember to carry your health ID card with you and always use a Blue Card PPO physician or hospital to decrease your costs. As long as you access these providers, you should not have to pay for any costs “up front”. If planning ahead, please contact 1-800-810-2583 and an Assistance Coordinator and medical professional will assist in arranging the care you need. If you become ill while you are away, please call Florida Blue collect at 1-804-673-1177. Hospitalization does require a pre-authorization.

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider may not balance bill you for covered services.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay the coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Copayment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your Insurance begins to pay. For example, if your deductible is $600, your plan won't pay anything until you've met your $600 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network Coinsurance usually costs you less than out-of-network coinsurance.

In-network Copayment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network Copayments usually are less than out-of-network copayments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Out-of-network Coinsurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance (deductible applies).

Glossary (cont'd)

Out-of-Network Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-contracted provider.

Out-of-Pocket Maximum: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred (In-Network) Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage: health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Prescription Drug Formulary: A list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. A committee of physicians, nurse practitioners, and pharmacists maintain the formulary. Some health insurance or plans do not cover non-formulary drugs or they are covered at a higher out-of-pocket cost.

Preventive Care: recommended care you receive, based on age and gender, to prevent illnesses or diseases. It also includes counseling to prevent health

Preventive Care (continued)

problems. These services are usually provided at no cost if you use your primary care provider or preferred provider. Once you have received a diagnosis, services are no longer considered preventive.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

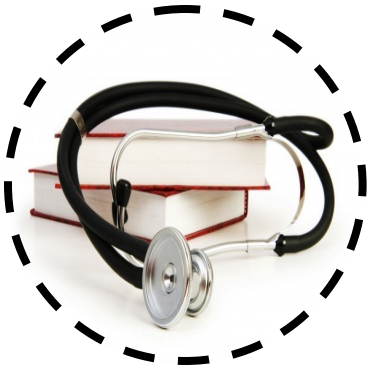
Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care-Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.



Health

The City of Gainesville offers its employees/retirees a very comprehensive health plan. Presently, the third party administrator is Florida Blue.

For 2017, there is only one health plan - BlueOptions.

BlueOptions offers covered participants the ability to choose any medical provider they wish. However, participants can maximize their benefits by choosing Network Blue "in-network" medical providers who participate in **Summary of Plan** Please see your group plan description for extensive detail of the coverage offered under the health plan. In the event of any discrepancy between this summary and the official plan document, the official plan document will govern.

	IN NETWORK	OUT-Of NETWORK
Calendar Year Deductible (CYD) - Individual	$600	
Calendar Year Deductible - Family *only effects contracts with 3 or more members	$1800	

Primary Care Office Visits Family Practice General Practice Internal Medicine Pediatrician	***In Network*** - $15.00 co-pay ***Out of Network*** - $600 CYD & 40% coinsurance
Specialty Office Visits-Except Some Mental Health Services	***In Network*** -$600 CYD & 20% insurance
Well Care Services at Primary Care or Specialist Discuss Your Needs with Your Doctor *Diagnostic and Screening Services subject to Age and Gender Appropriate medical guide lines. Examples: Annual Physical, OB/GYN annual visit, Stress Test, Diagnostic Laboratory Test, PSA tests, etc.*	***In Network*** - No Member Cost **Unlimited annual benefit** ***Out of Network*** - 40% coinsurance; **No Deductible**
Mammogram	Paid at 100% of the allowance. You may use any provider
Colonoscopy - **Routine (screening) Procedures only**	**In Network -** Member pays $0 for physician charges or facility charges for screenings only. **Out of Network**—payable at 100% of allowance; facility fee subject to $600 CYD and 40% coinsurance
Inpatient Hospital Care	***In Network*** Facility: *Option 1 $750 Co-payment *Option 2 $ 1,000 Co-payment Provider services for mental health—$50 per day co-pay Physician: $600 CYD & 20% co-insurance ***Out of Network*** - $600 CYD & 40% coinsurance
Outpatient Hospital Care	***In Network*** Facility.* *Option 1 $150 Co-payment *Option 2 $250 Co-payment
Mental Health/Substance Abuse, Physician Services **(at locations other than office, hospital & ER)**	***In Network -***$600 CYD & 20% co-insurance

* Option 1— North Florida Regional Medical Center—***Out of Network***—$600 CYD & 40% co-insurance
* Option 2— Shands Hospital at University of Florida

Emergency Room	***In Network*** - Facility: $250 co-pay Physician: $600 CYD & 20% coinsurance ***Out of Network*** - Facility: $250 co-pay Physician: $600 CYD & 40% coinsur-
Urgent Care Centers	$30 copay **Out of Network**—$600 Out of Network deductible and 40% coinsurance of the allowance
Free Standing Surgical Center	***In Network -*** Facility: $100 co-pay Physician: $600 CYD & 20% coinsurance of allowance **Out of Network**—$600 Out of Network deductible and 40%
Imaging / X-ray Services - Independent Diagnostic Facility	***In Network*** - Diagnostic services - $50 co-pay *(Except for AIS)* Advanced Imaging Services (AIS) - $125 co-pay *Examples: MRI, MRA, PET, CT, or Nuclear Medicine* *(Includes the test and the reading)*
Lab Services performed at **Quest Diagnostics**	Patient Pays $0
Lab Services performed anywhere that is not Quest Diagnostics (Hospital lab, physician's	***Out of Network*** - $600 CYD & 40% coinsurance All Labs other than Quest Diagnostics are considered "Out-of-Network"
Pharmacy Pharmacy - Generic	**$300 deductible applies to Preferred and Non-Preferred Drugs** $10.00 co-pay or actual drug cost (if less)
Pharmacy - Preferred Brand	$50.00 co-pay or actual drug cost (if less)
Pharmacy - Non-Preferred Brand	$80.00 co-pay or actual drug cost (if less)
Specialty Drugs	$160 co-pay

Mail Order Pharmacy: Get 90 days of medication for the cost of 2 monthly copayments. It's like buying 2 and getting 1 month FREE.

90-Day Supply for Maintenance Drugs only. The mail order program requires payment of co-pays even if the total cost of the drug is less than the co-pay.

Combined Therapy and Spinal Manipulations Note: Maximum Calendar Year Benefit—75 services May have medical guidelines	***In Network*** - $600 CYD & 20% coinsurance ***Out of Network*** - $600 CYD and 40% coinsurance
MAXIMUM OUT OF POCKET Individual/Family Aggregate Once met, medical services are paid at 100% for the remainder of the Calendar Year, including Pharmacy	***In Network*** - $4,500//$7,500 ***Out of Network*** - $5,000/ $10,000
EXCLUDES	♦ Non-covered charges
INCLUDES	♦ Calendar Year Deductible ♦ Coinsurance responsibility ♦ Pharmacy Co-payments

Retirement Planning

City Defined Benefit Pension Plans

The City of Gainesville has established and maintains two define benefit pension plans for its employees. The Consolidated Police Officers' and Firefighters' Retirement Plan covers any full-time regular employee who is certified as a firefighter as a condition of employment or any full-time regular employee who is certified or required to be certified as a law enforcement officer for the City of Gainesville. All other regular employees of the City of Gainesville are covered under the Employees' Pension Plan.

Participation in either pension plan requires a mandatory contribution from both the employee and the City of Gainesville. The City takes responsibility for producing the needed level of investment returns to meet the current and future pension benefit obligation of its retirees. Currently employees covered by the Consolidated Police Officers' Plan contribute 7.5% and employees in the Consolidated Firefighters' Retirement Plan contribute 9% of earnings during participation in the Plan. Those covered by the Employees' Pension Plan are required to contribute 5% of earnings during participation in the Plan. Contributions cease when an employee enters the Deferred Retirement Option Program (DROP).

These plans are tax-qualified defined benefit plans. Because the Plans are tax-qualified, you will not pay any income tax currently on the contributions you make to that Plan. Instead, you will be taxed when you receive benefits under the Plans, at which time you may be in a lower tax bracket than during your peak earning years. Because the Plans are defined benefit plans, your ultimate benefit depends upon factors such as your compensation level, years of service, and the form in which your benefits are paid.

The Plans are designed to provide a measure of economic security for retirement in addition to that provided by Social Security and your own personal savings. You are encouraged to establish and maintain your own retirement savings program and not to rely solely on Social Security and Employer provided retirement benefits.

Although both plans are very similar in how they work, each plan has different criteria to define eligibility, plan multipliers for benefit calculation, COLA eligibility and DROP eligibility.

Summary Plan Descriptions for all plans are located on both the Risk Management Internet site for the City of Gainesville http://www.cityofgainesville.org and the Risk Management Intranet site. These Summary Plan Documents (SPD) are updated every two years.

Supplemental Retirement Planning

Retiree Health Saving (RHS)

The City of Gainesville provides a Retiree Health Savings (RHS) plan which serves as a tool to help employees save money for post-employment medical expenses.

City of Gainesville regular employees (excluding Police, Fire, and CWA) contribute a mandatory 0.5% (half of a percent) to an RHS account on a bi-weekly basis.

City of Gainesville Police Lieutenants contribute a mandatory 5% (five percent) to an RHS account on a bi-weekly basis.

City of Gainesville Fire District Chiefs contribute a mandatory 2.5% (two and a half percent) to an RHS account on a bi-weekly basis.

City of Gainesville CWA covered employees contribute a mandatory 1.5% (one and a half percent) to an RHS account on a bi-weekly basis.

The money deposited into the account goes in tax-free, the earnings on the account grow tax-free, and the best part is, when you make a withdrawal for qualified medical, dental, vision, or long-term care expenses, the reimbursements from the account are tax-free.

A qualified expense is any out of pocket expense related to your health plan such as a deductibles, co-pays, non-cosmetic dental and vision services. Reimbursement can be made for the account holder and any eligible dependents.

The money in the account can start being withdrawn when the employee retires (or otherwise leaves employment).

Initially all funds are invested in the ICMA-RC Milestone Fund. However, this is your money and you can choose how to invest it. **Investment options can be changed by calling ICMA-RC at 1-800-669-7400 or logging on to the ICMA-RC website at www.icmarc.org.**

What are my options if I leave the City?

Cobra Continuation Coverage

Under COBRA—the Consolidated Omnibus Reconciliation Act of 1985, Title X, terminated employees and their eligible dependents may continue group health plan coverage. We urge you to read this description of the "continuation coverage" option carefully, and to make sure you read and understand the rights and responsibilities in connection with this continuation of coverage.

The Benefits

If you are currently covered under The City of Gainesville Health Plan, you will be entitled to continue your and your family's Health Plan coverage for up to 18 months from the date coverage would have terminated because of voluntary or involuntary termination. The 18-month period may be extended also if other events (such as a death or divorce) occur during that 18-month period. Dependents who no longer qualify as dependents under the City of Gainesville Health Plan are eligible to apply for continuation of coverage. If you should die or become divorced, and if your spouse and dependents are covered by the City of Gainesville Health Plan at that time, they will be entitled to continue health coverage for up to 36 months. If you have a new born child, adopt a child or have

A child placed in your home pending adoption (for whom you have financial responsibility), while your COBRA continuation is in effect, you may add this child to your coverage.

The Cost

Continuation of coverage is optional on the part of the employee or dependent. Those who elect continuation of coverage will be required to pay 102% of the total monthly group premium for the applicable class of coverage. There will be no contribution made by the City of Gainesville. Premiums are due monthly and in advance. You should note that your continuation coverage will stop if the premiums for this coverage are not paid on time. If you elect to continue coverage new dependents may be added during the period of continuation on the same basis as they are added for active employees. If during continuation of coverage, health benefits and premium rates change, your coverage and costs will be affected accordingly. Should open enrollment occur during the period of your continuation, you will retain your right to switch to a different option.

When Coverage Ends

If you or covered members of your family become entitled to Medicare or are covered under another employer-sponsored health plan, which does not limit coverage due to preexisting conditions, the continuation coverage from the City of Gainesville Health Plan will cease. In addition, your coverage will cease if City of Gainesville should terminate the Health Plan or you cease to pay premium. Once the period of coverage continuation has expired, anyone receiving continuation coverage will be eligible to convert to individual policies, as provided under the City of Gainesville Plan.

What happens to my 457 and/or IRA?

If you separate employment or retire, you have access to your supplemental investment accounts. Due to the IRS regulations and tax ramifications, the City suggests that you meet with your financial investment expert or contact Adam Ferguson with ICMA to schedule an appointment to discuss your options. Mr. Ferguson may be contacted at 866-928-4672 or at: afergson@icmarc.org.

What if I want to retire?

When you retire, your coverages will terminate at the end of the month of your retirement. You will need to meet with the Retirement & Pension Analyst 90 days prior to your retirement and you will receive information regarding your retirement calculation as well as the cost of your retiree health insurance. Retirees are only eligible for health insurance. If you wish to keep your dental or vision benefits, you will need to do so through COBRA. You will receive notice within two (2) weeks of your retirement from an independent company offering you continued coverage with COBRA rates. If you elect to continue these benefits, you would work directly with that vendor for your dental or vision coverage. Any other benefits that you wish to keep, you will need to contact that vendor directly to ask if converting to a personal policy is allowed.

Employee Health Services

Open Monday through Thursday 7:00am to 6:00pm
Fridays 7:00am to 5:00pm
Excluding Holidays
Phone: 352-334-5037 Fax: 334-3185

Employee Health Services provides many **FREE** and low cost benefits available to help reduce out of pocket health care expenses. Employee Health Services will not be your primary health care provider.

See the Nurse Practitioner for Acute Care Visits BY APPOINTMENT ONLY

Urgent Care Visits

(Treatment for):
Sore Throat • Ear Infections • Flu Symptoms • Dizziness • Rashes • Urinary tract infections • Lacerations
Many common generic medications prescribed during your visit are available for $4.00 each.

S.W.E.E.T.S. Program

Diabetes Management Program
Participation provides **FREE** monthly diabetic testing supplies, and waives the co-payment for generic medications used to treat diabetes, high blood pressure, and high cholesterol. Available to all employees, retirees and dependents on the health plan. Participation in PROClub is required.

Laboratory Testing

ALL Employees, Retirees and their Spouses on the City's Health Plan receive any labs drawn at Employee Health Services free of charge. Those without coverage on the health plan are eligible for ONE FREE health panel (inc's electrolytes, iron, kidney and liver functions, glucose, and lipids + PSA for males over 40) per calendar year. No doctor's order is required for this FREE Health Panel. All other laboratory testing requires a physician order. Some tests require special procedures. Please call to confirm availability for testing and to schedule an appointment.

Physical Exams

All employees are eligible for a "5 year physical" beginning at age 30, then every 5 years thereafter.

Injections

*__FREE__ Tetanus Vaccines
*Hepatitis A and B vaccines (small fee)
*__FREE__ Flu shots annually during October through December for Health Plan members. All others may require a small fee. (pending availability)."

Blood Pressure & Blood Sugar Checks

Live a healthier life. Monitor your blood pressure and blood sugar. Available FREE of charge by appointment.

Wellness Services

The City of Gainesville values the wellness of its employees. The City's Wellness Program offers a team of professionals to assist employees and their families establish and maintain a healthy lifestyle. This team includes experts in several areas: exercise physiology and athletic training.

Wellness Coaching Services

FREE Wellness Center Memberships • Personalized Exercise Program Design • Fitness Testing • Body Composition Evaluations • Group Exercise Classes • Health Education Classes • Basic Nutrition Guidance • Corrective Exercise Training

Athletic Training & Ergonomics Injury Assessment • Injury Rehabilitation • Injury Management • Brace Fitting • Crutch Fitting • Reconditioning • Fitness Assessment • Ergonomic Assessment and Training • Back Injury Prevention

PROClub

Available to ALL employees and spouses enrolled on the health plan. Between the months of February and October, participants earn points for certain healthy lifestyle activities. By meeting the minimum program point requirement, employees will receive a $350 rebate (additional $250 for spouses) from health insurance premium. The rebate is usually paid in early December. Well Care points are awarded for completing any service covered under adult Well Care Services.

Registration for participation in PROClub is required each year.

If you have any questions about any of your benefits, please contact representatives at the telephone numbers listed below:

City of Gainesville	
Risk Management Department	**(352) 334-5045**
Employee Health Services	**(352) 334-5037**
Employee Self Service (ESS)	https://ess.cityofgainesville.org/ESS

MEDICAL

Florida Blue - BlueOptions PPO	**1-800-664-5295**
WEBSITE	**www.floridablue.com**

457 DEFERRED COMPENSATION, ROTH IRA, RETIREE HEALTH SAVINGS

ICMA–RC	**1-800-669-7400**
WEBSITE	**www.icmarc.org**
Adam Ferguson	**1-866-328-4672**

GROUP TERM LIFE INSURANCE

SunLife Financial (formerly Assurant Employee Benefits)
1-800-733-7879