RFQ25-014

Request for Qualifications:
Employee Benefits Broker and Consulting Services

The City of New Port Richey (the “City”), Florida desires to procure proposals from qualified insurance brokerage firms (the “Consultant”) to provide employee benefits brokerage and consulting services for the City.

REQUEST FOR QUALIFICATIONS

RFQ25-014

Employee Benefits Broker and Consulting Services

- **Release of RFQ:** Friday, March 28, 2025
- **Deadline for Submittal:** Friday, May 2, 2025, 12:00 p.m. (EST)

Project Contact

Terri Kearnes, SHRM-SCP, CPM
Assistant Director, Human Resources and City Initiatives
City of New Port Richey
5919 Main Street, New Port Richey, FL 34652
p. (727) 853-1261 | e. kearnest@cityofnewportrichey.org

Project Description

The City of New Port Richey, Florida desires to procure proposals from qualified employee benefits insurance brokerage firms (the "Consultant") to provide employee benefits brokerage and consulting services. The City has approximately 210 benefit-eligible employees, with 168 employees currently enrolled in the City's fully insured plans, administered by Acrisure as the broker. The insurance plan year coincides with the City's fiscal year – October 1 through September 30. The City's benefit offerings include medical with prescription coverage, dental, vision, basic life and AD&D, an Employee Assistance Plan (EAP), supplemental life, HSA, FSA, and short- and long-term disability. Currently there are also a number of enhanced voluntary benefits, including supplemental insurance through Met Life.

The purpose of this Request for Qualifications is for the City of New Port Richey to receive responses from qualified firms to collaborate with the City's Human Resources & Risk Management team. The final selected consultant will assist with plan design, identify best practices and trends in benefits, select insurance carriers, and provide ongoing support in areas such as needs assessment, plan management, funding projections, compliance, marketing, annual renewals, and increasing employee engagement and benefit knowledge.

Submittal Procedures

Firms shall submit three (3) hard copy submittals, **in addition** to a thumb drive. Responses must be submitted by 12:00 pm (EST) on Friday, May 2, 2025. Statements of qualifications not submitted by that time will not be accepted. Statements of qualifications shall not be valid unless sealed in a single envelope or box marked:

City of New Port Richey

RFQ 25-014, Employee Benefits Broker and Consulting Services
Attention: City Clerk
5919 Main Street
New Port Richey, Florida 34652

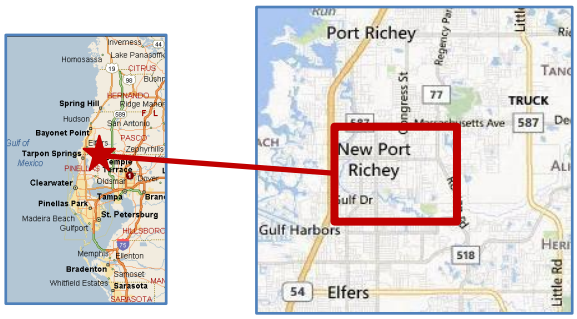
Proposals are due no later than the date and time noted above. Any proposal received after that date and time will not be accepted. Any individual requiring special assistance must notify the Project Contact in writing 48 hours in advance so that arrangements can be made.

Type of Contract

The Consultant contract will be a multi-year contract with a minimum two (2) one-year option to renew, mutually agreeable by both parties. The City may, at its discretion terminate any agreement by notifying the Broker/ Consultant prior to the commencement of work on the plan for a particular fiscal year. The City retains the option to solicit new proposals at any time, if in its best interest. A contract must be completed on or before June 30, 2025.

City Background

The City of New Port Richey is 4.6 square miles located on the west coast of central Florida. Situated in the western edge of Pasco City, the City is part of the Tampa Bay area. It is ideally situated along the Gulf of Mexico with an attractive climate. The City was incorporated in 1924 and has grown to nearly 17,500 residents. New Port Richey is a residential community with a strong local government and an attractive historical downtown and Main Street. The City has a broad array of businesses and retail services and is most recognized for its cultural heritage and unique riverfront landscape.



Tampa Bay New Port Richey

Submittal Requirements

Firms or individuals wishing to provide employee benefits broker and consulting services to the City of New Port Richey pursuant to this request shall apply for consideration. Information should be concise and specific to address each request. All respondents seeking a contract must meet the following requirements and include evidence of each in their submittals:

- Contain a letter of interest;
- Must have completed similar work within the State of Florida, and/ or Pasco/ Pinellas County area within the last two (2) calendar years;
- Must be licensed and registered in the State of Florida;
- Must have at least five (5) years of experience providing the requested services.
- Provide a brief description of the history and capabilities of the firm including organizational chart and the resumes of the key persons who may be assigned, from time to time;
  - Include the name of the Consultant who will have the main contact with the City. This individual is expected to remain as the point of contact throughout the engagement.
- Information on the Respondent's ability to handle the assigned work with the current staff and the workload already assigned to the key persons;
- Provide a list of all other local governments currently being represented by the Respondent;
- Provide at least three references from these organizations including names, contact persons, and phone numbers;
- Must disclose any past or present financial relationship to any and all insurance companies, Third Party Administrators (TPA), and/or any other providers of services similar to the those that may be provided to City of New Port Richey.

- Describe any conflicts of interest or ethical considerations related to representation or affiliation with any boards, organizations, committees, or clients, including, but not limited to, other municipalities, governmental, and/or quasi-governmental entities;
- Provide a list and explanation of any ethics complaints or lawsuits filed against the Respondent(s), and a list of any other, similar claims against the Respondent(s), in the last five (5) years;
- The location of staffing and firm resources are expected to be made available to serve City of New Port Richey;

Scope of Services

The City is soliciting proposals for the services of an Employee Benefits Broker and Consulting Services firm to strategically plan, consult, implement, and support the City's employee benefits program. The selected firm will work closely with the City's Human Resources & Risk Management personnel as a proactive partner in assisting with achieving the most beneficial plan funding designs, identifying best practices and current trends in benefit offerings, selecting insurance carriers and benefits providers. The Consultant may also assist the City with the design and development of Request for Proposals (RFPs), as well as evaluating and identifying high value proposals and comprehensive services for each benefit offered to City of New Port Richey employees, including but not limited to: Medical, Prescription Drug and Dental plans, Basic Life Insurance with AD&D, Voluntary Life Insurance, Vision Insurance, Short-term and Long-term disability, HSA/HRA, FSA, COBRA, retiree benefits, a Wellness program, disease management and preventive care options, and an effective Employee Assistance Plan (EAP).

The City is particularly interested in an employee benefits consulting firm with a proven track record that can offer creative, innovative approaches which will allow the City to obtain quality benefits and contain or reduce overall costs. The contracted firm may be required to provide a self-service, internet-based solution that can electronically transmit benefit data to multiple carriers for various insurance products. The awarded Consultant shall provide services, including, but not limited to:

1. Review, on an ongoing basis, the existing employee benefit programs for competitiveness, appropriateness and overall acceptance by plan participants.
2. Analyze existing coverage, identify, and develop cost-saving alternative benefit strategies and plans.
3. Provide innovative approaches to benefit challenges facing the City of New Port Richey and recommendations for benefit plan changes.
4. Recommend appropriate premium rates and reserves, and the most economical funding methods to maintain the viability of each benefit plan to ensure that quality and cost-effective benefits are provided by the plans. This includes evaluation of both fully insured and self-funded options, for both current plan year and upcoming plan year.
5. Determine annual estimates of renewal rates and cost trends and assist City staff in preparation of budget figures.
6. Assist in the development of short and long-range goals and strategies, including making projections of potential savings.
7. Serve and assist the City in negotiating benefits provider contract(s) resulting from the review and recommendations noted above including the use of available provider networks.
8. Assist the City with plan design changes, plan implementation strategies, plan design and/or benefits communications relating to coverage;
9. Provide periodic reports using carrier data on claims and fixed expenses, and relate those to total premium and expectations for renewal.
10. Provide assistance to City staff, and employees, with issues involving provider billing, claims, vendor service issues/problems, advocacy for services, disputes, interpretation of contracts and services, changes and general troubleshooting.
11. Attendance, as needed, at meetings with City staff, elected officials, and employees to facilitate

and assist in the management of the City's employee benefits plans.
12. Attend and assist with coordination of Annual Open Enrollment meetings and Employee Benefits Fair.
13. Attend on-site annual open enrollment meetings and continuing enrollment services as appropriate for both current and new City of New Port Richey employees.
14. Assist with ongoing plan administration and ensure that City benefit programs comply with State and Federal regulations.
15. Review and disseminate information to City staff, on an ongoing basis, regarding new or revised State and Federal legislation that impacts benefit programs.
16. Assist City staff in ensuring compliance with all mandated reporting and posting/notice requirements for benefit plans.
17. Develop and assist in creating, as needed, various communication materials and tools including, but not limited to, open enrollment annual meetings, new hire orientation, qualifying events and wellness programs.
18. Assist in the ongoing process of maintaining an employee wellness program, to improve employee health and reduce employee health-care costs, both in the short and long-term.
19. Assist in research of the available options of web site technologies to support on-line enrollments, qualifying event changes and employee education to assist employees in self-management of benefits.

RFQ Schedule*

It will be incumbent on each respondent to understand the importance of adhering to the schedule included herein. Respondents shall assume full responsibility for the timely delivery of submittals. Those received after the deadline stated will not be accepted. (Dates are subject to change*)

Schedule	Date
RFQ Release	Friday, March 28, 2025
RFQ Submission Deadline	Friday, May 2, 2025 by 12:00pm (EST)
Interviews and Discussions	Wed., May 21, 2025 – Friday, June 6, 2025
Recommendation to City Council	Tuesday, June 17, 2025

Requirement of Responses

The response must be organized according to the following format. Include a table of contents and tabs to organize the material.

- Cover letter,
- Resumes;
- Organizational Charts,
- References,
- Certifications and affidavits,
- Vendor Qualification forms,
- W-9,
- Financial statements.
- Information on prior contract terminations;
- Information on name changes/ corporate restriction

Evaluation and Selection Process

A City review team will evaluate each firm's submission based upon the criteria stated in this Request for Qualifications and the ability to execute the services. The top firms will be presented to Council to engage in further discussions. The team will then select the firm that the City considers most qualified and make a recommendation to City Council. Upon its approval, the

successful Firm will be requested to enter into negotiations to produce a contract for this service. The City reserves the right to negotiate modifications to Statements of Qualifications that it deems acceptable. The City reserves the right to terminate negotiations in the event it deems the progress towards a contract to be insufficient.

Firms will be evaluated in accordance with the weighted criteria listed below.

Criteria		Weight
1	Service Design & Methodology	25%
2	Experience working w. local and state agencies	25%
3	Qualifications of Key Personnel	20%
4	References	15%
5	Location of Firm and Staff Assigned to this Project	15%

Other Provisions:

- Reserves the Right
  The City reserves the right to reject any and all submittals, or any part of any submittal, to waive any irregularities or informalities in any submittal, and to accept that submittal which is deemed to be in the best interest of the City. The City reserves the right to establish additional contracts that may be similar in nature to any contract resulting from this RFQ as best serves the needs of the City.
- Insurance Requirements
  The Respondent, if awarded a contract, shall maintain insurance coverage reflecting the minimum amounts and conditions as required by the City. The awarded firm must file certificates of insurance with the City prior to commencement of work evidencing the City as a certificate holder as additionally insured.

- No Collusion
  By offering a submission to this RFQ, the responder certifies that no attempt has been made or will be made by the responder to induce any other person or firm to submit or not to submit a submission for the purpose of restricting competition. The only person(s) or principal(s) interested in this submission are named therein and that no person other than those therein mentioned has/have any interest in this submission or in agreement to be entered. Any prospective firm should make an affirmative statement in its proposals to the effect that, to its knowledge, its retention would not result in a conflict of interest with any party.

- No Conflict
  The Respondent and subconsultants shall disclose in the submittal all contracts or projects for which they have potential or actual conflicts of interest with this contract. Failure to identify potential or actual conflicts of interest constitutes grounds for rejection of the submittal without further review. If such conflicts are discovered during the term of the Contract, the City of New Port Richey may terminate the Contract for default. The existence of potential or actual conflicts of interest will be used as an evaluation criterion regarding team availability during the evaluation and selection process.

- Application of Drug Free Workplace Act
  All Respondents shall represent that they have established drug free workplaces.

- Public Entity Crime
  Section 287.133(2)(a), *Florida Statutes*, states "A person or affiliate who has been placed on the convicted vendor list, following a conviction for a public entity crime, may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity in excess of the threshold amount, provided in s.287.017 for CATEGORY TWO, for a period of 36 months following the date of being placed on the convicted vendor list." All submittals must be accompanied by an executed form PUR 7068.

- Costs for Submittals
  The City Council will not reimburse for any costs associated with the preparation and submittal of any proposal, for any travel and/or per diem costs.

- Submittal Withdrawal
  After submittals are opened, corrections or modifications to submittals are not permitted, but a respondent may be permitted to withdraw an erroneous submittal prior to the award by the City Council, if the following is established:
  - That the respondent acted in good faith in submitting the submittal;
  - That in preparing the submittal there was an error of such magnitude that enforcement of the submittal would create severe hardship upon the respondent;
  - That the error was not the result of gross negligence or willful inattention on the part of the respondent;
  - That the error was discovered and communicated to the City within twenty-four (24) hours of submittal opening, along with a request permission to withdraw the submittal;
  - The respondent submits documentation and an explanation of how the error was made.

Certification of Information Provided

I certify that the information and responses provided on this submittal are true; accurate and complete. The City of New Port Richey or its representatives may contact any entity or reference listed in this submittal. Each entity or reference may make any information concerning the Respondent available to the City.

_____

Signature

_____

Printed Name

As _____(title)

Dated this _____day of_____, 20__.

STATE OF _____}

CITY OF _____}

On this _____day of _____, 20 _, before me the undersigned authority, personally appeared _____, to me known to be the individual described in and who executed the forgoing instrument as _____ (title) of the firm of _____and acknowledged the execution of same, for and on behalf of and as the act and deed of said firm, for the uses and purposes therein expressed.

WITNESS my hand and official seal the date aforesaid.

_____ [ ]

(Signature of Notary Public - State of Florida)

_____

(Print, Type or Stamp Commissioned Name)
Personally known _____
Or produced identification _____

Type of identification produced _____

Appendix A

2024 – 2025 Employee Benefit Highlight Book

THE CITY OF
NEW PORT
RICHEY
FLORIDA

EMPLOYEE BENEFIT GUIDE

PLAN YEAR: October 1st, 2024 – September 30th, 2025

ACRISURE®

CONTENT

Information provided by

ACRISURE®

We strive to provide you with a comprehensive employee benefits program as part of your overall compensation package.

We put together this guide to help you understand your benefits and to help you get the most out of them. We encourage you to review it thoroughly so you can identify which offerings are best for you and your family.

If you have questions about your benefits, reach out to Human Resources or use the contact information included in this guide to get the answers you need.

This Employee Benefits Guide is designed to provide information about the benefit plans and programs offered by our organization during the plan year listed on the front cover. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs described herein. This booklet does not constitute a Summary Plan Description (SPD) or Plan Document as defined by the Employee Retirement Income Security Act (ERISA). If there is a conflict between this document and the SPD, the SPD shall prevail. The SPD is available from our Human resources department.

WELCOME TO
OPEN ENROLLMENT

Dear City of New Port Richey Employee:

We are pleased to announce our benefits line-up for the **October 1, 2024—September 30, 2025** plan year, in conjunction with our employee benefits broker—**Acrisure**. Your management team is extremely committed to your well-being and satisfaction with the group benefit plans. A summary of the key changes & highlights are as follows:

Medical Insurance benefits will move to FL Blue and offering three plans options. The City will be contributing $1200 annually, broken down to $300 quarterly contributions.

HSA Banking – If you enroll in the HSA Plan, The City will open your account with HSA Bank and deposit $1,200. You will receive a debit card in the mail. You can also payroll deduct additional amounts up to the IRS Annual Limit.

Flexible Spending Accounts will remain with Ameriflex. The annual limit for the health FSA is $3,200 and you can rollover up to $640 of unused funds to the next plan year. Any employee with rollover funds on 9/30/24 who elects to enroll in the new HSA will need to move to a Limited Purpose FSA (can be used for dental & vision expenses only).

Dental & Vision Insurance will remain with Metlife with no changes to plans or rates.

Life and Disability benefits will remain with Metlife. This includes basic life, voluntary life, long term disability (LTD) and short term disability (STD). There are no changes to plans or rates, unless your salary increases or you move into a new age band.

Voluntary Supplemental benefits will remain with MetLife. This includes Accident, Critical Illness, and Hospital coverage.

Benefit Guides: you will find important information about each of the benefits available to you and your eligible dependents. Please read it carefully so you fully understand the options available to you so you can make the best choice for your health and the health of your loved ones. You can access the Benefit Guide on the Benefits Connect online portal.

Live Open Enrollment Meetings are scheduled at various City locations between 8/28-8/30. Please get with your Department Head for details on when/where each session is scheduled.

You are required to go online to the GIS BenefitsConnect portal to enroll, decline, or update your benefits—even if you are keeping everything the same or declining at:

https://www.benefitsconnect.net/cityofnpr

What You Need To Get Started…

During the enrollment process you will be asked to provide some basic information that you should have available.

- Your dependent's social security numbers and birth dates
- If electing DHMO Dental – Please research the Metlife website for your primary dentist and enter a Facility ID, or a dentist will be selected on your behalf by Metlife. You can call Metlife to change your primary dentist after 10/1.

Username and Password

Your username is made up of the first six letters of your last name, followed by your first initial and the last four numbers of your social security number. The initial password for the system is your social security number (without dashes).

Note: If your last name is not six letters please use your entire last name, first initial and last four of your social security number as your username.

The Benefits Connect portal will open for elections on 8/28/24 thru 9/12/24. If you have benefits questions or want assistance making your elections online, you can schedule a time with HR for a 15 minute virtual session. The virtual sessions are available for scheduling on Monday, 9/4/24 between 9:30am – 4:30pm.

ELIGIBILITY

Employees

All full-time employees are eligible for benefits on the first day of the month following 30 days of employment. To be eligible for benefits, employees must work at least 30 hours per week. Retirees are also eligible for medical & dental benefits only.

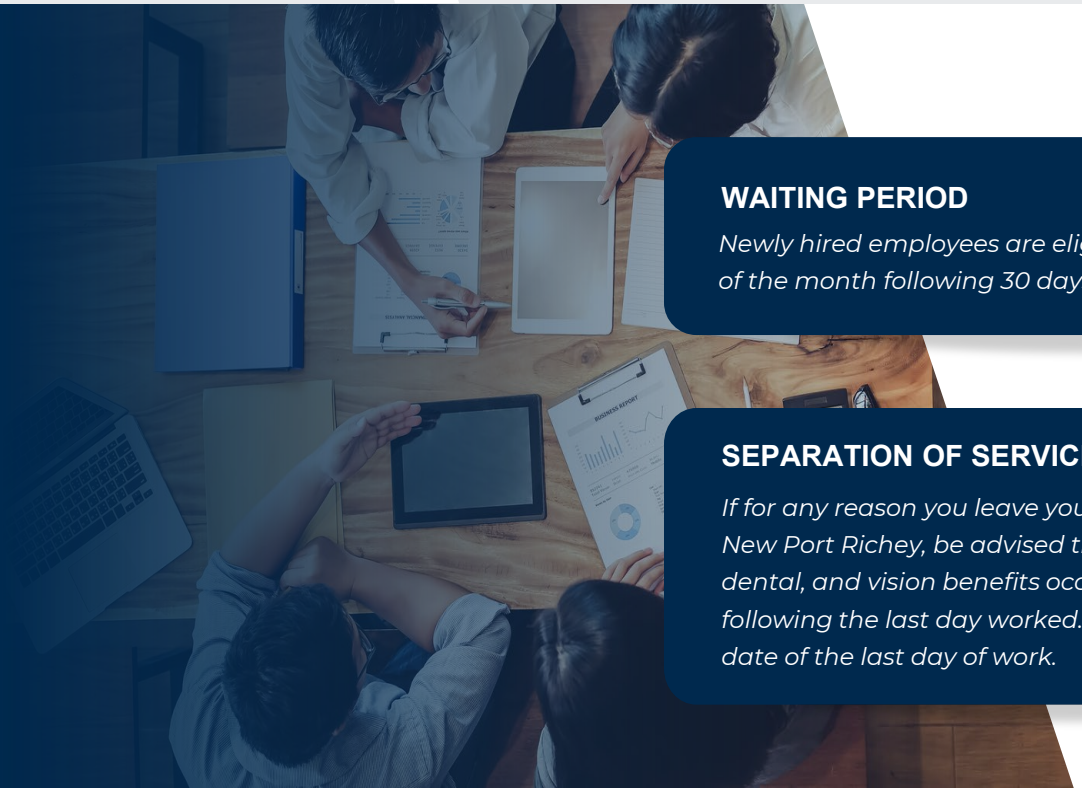
Dependents

Your eligible dependents may also participate in the plan; however, your dependents may not enroll in the plan unless you are also enrolled in that plan. An eligible dependent is considered to be:

- Your legal spouse
- You or your spouse's child including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian who meets the below age restrictions:

Medical	Dependent children covered to the end of the calendar year when they turn 30.
Dental and Vision	Dependent children are covered up to age 26.
Voluntary Life and AD&D	Dependent children may be covered up to age 26.

- A child who is primarily supported by you and incapable of self-sustaining employment by reasons of mental or physical handicap (proof of their condition and dependence must be submitted).
- A dependent also includes a child for whom healthcare coverage is required through a Qualified Medical Child Support Order or other court or administrative order.



WAITING PERIOD

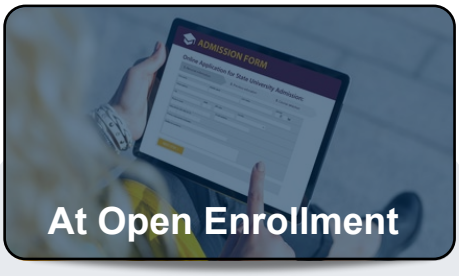
Newly hired employees are eligible for benefits on the first day of the month following 30 days of employment.

SEPARATION OF SERVICE

If for any reason you leave your employment with the City of New Port Richey, be advised that termination of medical, dental, and vision benefits occur on the last day of the month following the last day worked. All other benefits terminate the date of the last day of work.

BENEFIT
ELECTIONS AND CHANGES

There are limited opportunities to enroll and/or make changes to your benefit elections. Make your selections carefully! The choices you make now will be effective through the end of the plan year, as long as you remain eligible.



At Open Enrollment

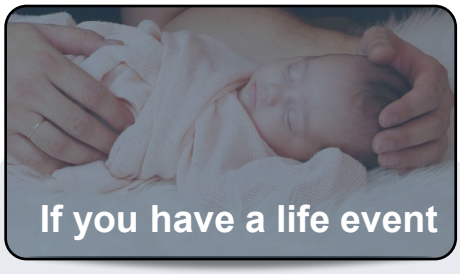
Open Enrollment is your annual opportunity to make changes to your elections.

Benefits selected during Open Enrollment are effective October 1, 2024.

When you're first hired

The benefits you elect begin on the first day of the month following 30 days of employment.

Human Resources will coordinate a session with Enroller or you can elect to independently make your elections in the Benefits Connect system, preferably at least 10 days prior to your effective date for coverages.



If you have a life event

Some life events allow you to change your coverage during the year. If you experience a life event, you have 30 days from the date of the event to request changes and provide the required documentation.

Some common life events are:

- Birth or adoption
- Marriage or Divorce
- Change in employment status or change in coverage under another employer-sponsored plan
- Loss or gain of eligibility under Medicare or Medicaid

Please submit your request for a benefit change following a life event to Human Resources. These requests are subject to verification and approval.

GIS

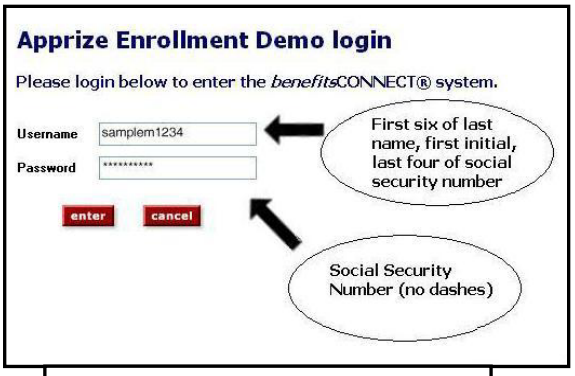
HOW TO ENROLL ONLINE

City of New Port Richey employees have access to online enrollment with Benefits Connect—it's a simple, secure online enrollment system that allows you to elect your benefits in minutes from any computer with internet access. After enrolling online, you will have access to your benefit information 24 hours a day, from any computer. For your security Benefits Connect is 128-bit encrypted and password protected. Follow the steps below to learn how to access the system and enroll at:

https://www.benefitsconnect.net/cityofnpr

What You Need to Get Started
During the enrollment process you will be asked to provide some basic information that you should have available.

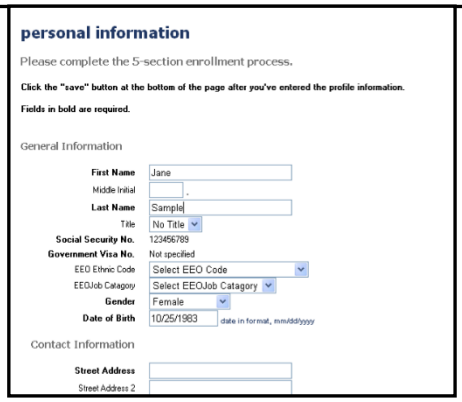
- Your social security number
- Your dependent's social security numbers and birth dates
- If electing Lincoln – DHMO Dental plan – search and enter six digit DHMO Office Number to elect a primary dentist (dentist search instructions on dental page of this guide)



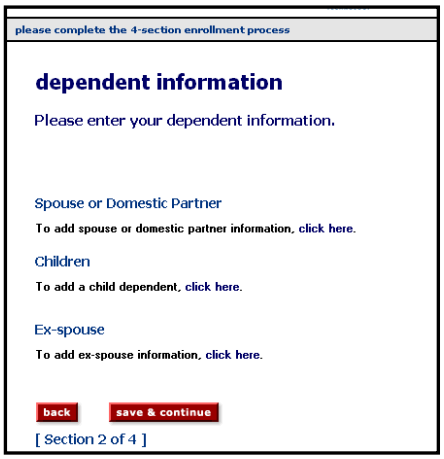
Username and Password
Initially your user name and password are defaulted to a standard format. Upon completing your first login you will be prompted to change your password. Let's walk through a sample login.

Your **user name** is made up of the **first six letters of your last name**, followed by your **first initial** and **the last four numbers of your social security number**. The **initial password** for the system is your **social security number** (without dashes).

Example: Employee Name: Matt Sample
Social Security Number: 949-12-1234
User Name: samplem1234
Password: 949121234



Entering Personal Profiles
After your initial login, the system will take you to the Personal Information section. Please complete all fields. **Bolded** fields are required, and must be completed. When you have completed all of the fields, click *save & continue* to proceed to the next screen.



Entering Dependent Profiles
The system will now take you to the Dependent Information section: To enter a spouse, click the icon under Spouse, enter information, and click *Save*.

To enter a child, click the icon under Children, enter information, and click *Save*.

To edit a dependent, click the pencil icon next to the dependent you want to edit, make changes, and click *Save*.

Note: You only need to add dependents that you would like to enroll for coverage. You will choose which dependents to enroll for each plan when you reach the election screens.

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HOW TO ENROLL ONLINE

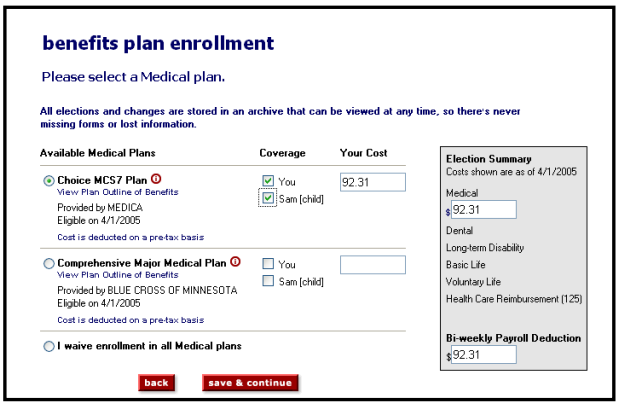
Making Benefit Plan Elections
Next, the system will take you to the Benefit Plan Enrollment Section. Each benefit and your options will be displayed one by one.
To enroll in a plan, check next to the plan, and check any dependents you want to cover. If applicable, indicate the amount for which you would like to enroll.

To waive coverage, check next to *I waive enrollment*.

For information about a plan, click *View Plan Outline of Benefits*.

For plans provided by your company at no cost to you, enrollment is already checked.

Click *Save & Continue* after each benefit selection.



Completing Your Enrollment
Once you have gone through enrollment for each plan available, the system will take you to the consolidated enrollment form page. This screen will show you a summary of the information you entered and the benefit elections you made.

To complete the enrollment process: Please Click *Finished*.

If you need to log off before completing enrollment, any data you entered will be saved. The next time you log on, you will be taken directly to the last saved screen.

Always make sure to *log out* upon completing any action on the system.

For Online Enrollment Technical Assistance:

Please call GIS Benefits, Inc. at 1.727.209.4227 ext. 0 (Customer Service) Our office is open Monday through Friday from 8:30 am to 5pm. If you are prompted to leave a message, someone will return your call within 1 business day.

MEDICAL INSURANCE
FLORIDA BLUE

You may choose from three medical plans through Florida Blue. When selecting your medical plan consider:

- The premium you'll pay (your payroll deduction)
- What you'll pay when accessing care (copays, deductible, coinsurance and max out of pocket)
- What medications are covered (also find out which coverage tier; and whether generics and/or mail order are available)
- Which providers are In-Network

SOME INSURANCE TERMS

COPAY
A fixed amount you pay when seeking care for certain services.

DEDUCTIBLE
The amount you pay for certain health care services in a calendar year before the plan begins paying any portion of those services. Embedded means per person deductible; non-embedded means a full family deductible.

COINSURANCE
The percentage you pay for certain services after meeting your deductible and before you meet your Out of Pocket Maximum.

OUT OF POCKET MAXIMUM
The most you will pay in a calendar year for covered services. This includes copays, deductibles, coinsurance, and prescriptions. Once the Out of Pocket Maximum has been met, the plan will pay 100% of covered services for the remainder of that calendar year.

BALANCE BILLING
The amount you are billed by Out-Of-Network providers to make up the difference between the amount they charge and what the insurance reimburses. This amount is in addition to and does not count toward your Out of Pocket Maximum.

	Blue Options 05196/05197 (HSA)	Blue Options 05302 (10/50/80/250 Rx)	Blue Options 05771 (10/50/80/250 Rx)
What Provider Network do I use?	Blue Options	Blue Options	Blue Options
Do I need to choose a Primary Care Physician (PCP)?	No	No	No
Do I need a referral to see a Specialist?	No	No	No
Can I go Out-Of-Network?	Yes. This plan has out-of-network benefits but you will incur additional expenses using out-of-network providers.	Yes. This plan has out-of-network benefits but you will incur additional expenses using out-of-network providers.	Yes. This plan has out-of-network benefits but you will incur additional expenses using out-of-network providers.
Where can I go for blood work?	In Florida; Quest. Outside Florida; refer to Provider Directory		

NON-SMOKER

Medical Bi-Monthly (24) Payroll Deductions – PRE-TAX

	Blue Options 05196/05197 (HSA)	Blue Options 05302 (10/50/80/250 Rx)	Blue Options 05771 (10/50/80/250 Rx)
Employee	$24.01	$47.80	$81.50
Employee + Spouse	$75.57	$140.77	$185.50
Employee + Child(ren)	$69.93	$122.00	$163.00
Employee + Family	$136.83	$211.50	$260.00

SMOKER

Medical Bi-Monthly (24) Payroll Deductions – PRE-TAX

	Blue Options 05196/05197 (HSA)	Blue Options 05302 (10/50/80/250 Rx)	Blue Options 05771 (10/50/80/250 Rx)
Employee	$150.09	$183.86	$224.70
Employee + Spouse	$301.73	$369.79	$438.48
Employee + Child(ren)	$285.15	$349.64	$414.58
Employee + Family	$481.91	$590.88	$700.71

MEDICAL INSURANCE
FLORIDA BLUE

BENEFIT SUMMARY	Blue Options 05196/05197 (HSA)	Blue Options 05302 (10/50/80/250 Rx)	Blue Options 05771 (10/50/80/250 Rx)
In Network Names	**Blue Options**	**Blue Options**	**Blue Options**
Financials			
Deductible	$3,500 Per Individual $7,000 Family Max	$5,000 Per Individual $10,000 Family Max	$1,500 Per Individual $4,500 Family Max
Coinsurance	20% after Deductible (Ded)	30% after Deductible (Ded)	20% after Deductible (Ded)
Maximum Out of Pocket	$6,850 Per Individual $7,000 Per Individual with Dependents Enrolled $14,000 Family Max	$6,350 Per Individual $12,700 Family Max	$4,500 Per Individual $9,000 Family Max
Physician Services			
Preventive Care	No Charge	No Charge	No Charge
Primary Care	$30 copay after Ded	$30 copay	$30 copay
Specialist	$75 copay after Ded	$55 copay	$55 copay
Hospitalization			
Inpatient Hospitalization	20% after Ded	30% after Ded	20% after Ded
Outpatient Surgery	20% after Ded	30% after Ded	20% after Ded
Physician Services (Hospital & ER)	20% after Ded	30% after Ded	20% after Ded
Urgent Care	$100 copay after Ded	$60 copay	$60 copay
Emergency Room	$350 copay after Ded	$300 copay	$250 copay
Outpatient Diagnostics			
Routine Diagnostics (Lab & X-ray)	20% after Ded	Lab: No copay X-ray: 30% after Ded	Lab: No copay X-ray: $50 copay
Major Diagnostics (MRI, CAT, PET Scans, etc.)	20% after Ded	30% after Ded	$250 copay
Prescriptions			
Rx Deductible	Medical & Rx Deductible Combined	None	None
Tier Level 1	$10 copay after Ded	$10 copay	$10 copay
Tier Level 2	$50 copay after Ded	$50 copay	$50 copay
Tier Level 3	$80 copay after Ded	$80 copay	$80 copay
Tier Level 4	$250 copay after Ded	$250 copay	$250 copay
Mail Order Pharmacy	2.5 x retail copay after Ded (90 day supply)	2.5 x retail copay (90 day supply)	2.5 x retail copay (90 day supply)
Out of Network			
Deductible	$7,000 Per Individual $14,000 Family Max	$10,000 Per Individual $30,000 Family Max	$4,500 Per Individual $13,500 Family Max
Coinsurance	40% after Deductible (Ded)	50% after Deductible (Ded)	50% after Deductible (Ded)
Maximum Out of Pocket	$13,700 Per Individual $27,400 Family Max	$20,000 Per Individual $40,000 Family Max	$9,000 Per Individual $18,000 Family Max

Note: Your medical deductible runs on a calendar year basis, meaning it will reset to zero on 1/1/2025 & will accumulate until 12/31/2025

The City will deposit $1,200 in to your HSA Bank Account, $300 deposited quarterly to your HSA account. The City will open your account with HSA Bank and you will receive a debit card in the mail. If you already have an HSA Bank account, we will deposit to your current account.

MEDICAL INSURANCE
FLORIDA BLUE

When you enroll in any of the Florida Blue medical plans, you are able to access a variety of programs designed to help you get the most out of your health plan and to improve your overall health and well-being.

Register as a member at www.floridablue.com after you receive your ID Card to learn more and to use these programs.

FloridaBlue.com	Visit FloridaBlue.com to sign up for your secure Member Account. You will need your Member Number which is located on your Florida Blue ID card. Follow the prompts to set up your User ID and password to complete the registration.
Florida Blue Mobile App	Download the Florida Blue Mobile app today! Check plan benefits and see the status of your claims. Find the nearest in-network doctor, Urgent Care Center or pharmacy. Compare medical costs. View your member ID card
Teladoc Virtual Visits	Visit a doctor virtually using your mobile device, tablet or computer 24/7 while enrolled in any of the Florida Blue medical plans. Virtual visits are ideal for things ling bronchitis, a cold or the flu, fever, a rash, sinus problems, sore throat, stomachache and more. A doctor will give you a diagnosis and if necessary a prescription.
Better You Strides	Free online wellness program that uses your needs, goals and interests to build your customized plan to better your heath. To register for this program first log in to your Florida Blue online account at FloridaBlue.com. Find "Your Guide to Better Health" on the right side of your home page and client "Get Started". Follow the prompts to create your account.
Nurses on Call	When you need answers right away, you can call a health coach 24/7. This is a great feature if you or your family members have health concerns or general health questions. Nurseline is available at no cost. Simple call 877.789-2583.
Healthy Addition Prenatal Program	The Healthy Addition program works with you and your health care provider to help you have healthy pregnancy. For more information email healthaddition@floridablue.com or call 800.955.7635, Option 6 Monday – Friday 8 AM – 5:30 PM EST.

TO FIND AN IN-NETWORK MEDICAL PROVIDER

TO LOCATE PROVIDERS IN FLORIDA

- Go to www.FloridaBlue.com
- Click 'Find a Doctor'
- Select the Blue options network and follow the prompts

TIP When looking for specific providers, less data often returns better results. Start with the location and type of provider. When searching by name, enter only the first few letters of the provider's last name.

TO LOCATE PROVIDERS OUTSIDE OF FLORIDA

- Click 'Find a Doctor'
- Scroll to bottom of the page, click on Doctors & Hospitals Nationally
- Enter your location (zip code or city and state).
- Enter the three letters at the beginning of your Member ID
- Follow prompts for type of provider search.

A NOTE ABOUT FLORIDA BLUE PROVIDER NETWORKS

The Florida Blue, Blue Options network provides coverage nationally for any PPO providers in the state's Blue Cross/Blue Shield network. Blue Options also has coverage for out of network providers.

WHY CONSIDER AN HSA?

WHAT IS AN HSA

OWNERSHIP
- You control and manage your healthcare expenses
- Take it with you if you leave your employer

COST SAVINGS
- Lower Premium
- “Triple Tax Advantage“

LONG TERM FINANCIAL BENEFITS
- Save for future medical expenses – “medical retirement account”
- Funds roll over year to year; interest bearing

VOLUNTARY TAX-FAVORED BANK ACCOUNT

Entirely your money, deducted from payroll pre-tax; grows tax free and is spent on qualified expenses tax free.

- Owned by you, the participant – fully portable and rolls over
- You cannot be on Medicare or other (such as spouse’s) medical plan; or have used VA benefits within past 3 months

2025 Contribution: $4,300 (single); $8,550 (family); plus $1,000 catch up for 55+

- 2024 Limits: $4,150 (s) and $8,300 (f), and can be deposited until 4/15/25
- Designed to pay for Qualified Medical Expenses – medical/pharmacy, dental, vision, etc.
  - Pay for deductible, coinsurance, copays, etc.
  - Also spend for dependents, even if not on your medical plan
  - List of QMEs available at www.irs.gov/publications/p502

PART 1: HIGH DEDUCTIBLE HEALTH PLAN

SAMPLE PLAN	SINGLE	FAMILY
Calendar Yr Deductible	$3,000	$6,000
Max. Out of Pocket	$6,000	$12,000

PART 2: HEALTH SAVINGS ACCOUNT

FOR 2024	SINGLE	FAMILY
**Maximum Contribution	$4,150	$8,300

HEALTH SAVINGS ACCOUNT TIPS

A Health Savings Account, commonly referred to as an HSA, is a bank account that may be funded with tax-exempt dollars. The money in an HSA may be used to pay for unreimbursed medical expenses on a tax-free basis. You must meet the qualifications defined by the IRS in order to open or make contributions to an HSA.

HELPFUL HINTS: DOCTOR'S OFFICE AND PAYMENT

- SHOW YOUR HEALTHCARE CARD.
- Review your Explanation of Benefits from your health insurer and utilize on-line system to follow your claims (deductible satisfactions and out-of-pocket maximum).
- Compare your health provider invoice to the Explanation of Benefits from your health insurer to ensure that you accurately pay the health provider. Any charges from your in-network health provider above the amount stated on the Explanation of Benefits should be reimbursed to you by the health provider directly.
- Utilizing an in-network provider entitles you to a discounted rate and that any applicable amounts paid to the provider are credited to your deductible and maximum out of pocket limits on your health plan.
- If you have a medical expense early in the year that is more expensive than the total of your HSA bank account, you will need to pay that amount from your personal checking account. However, you can reimburse yourself once the funds accumulate in the HSA account. Keep in mind—you can always place expenses on a credit card or attempt to establish a payment plan with the provider.

QUESTIONS TO ASK THE DOCTOR

- Understand your diagnosis/condition—Discuss openly with your physician.
- Is there a generic prescription equivalent that will work just as well?
- What can I be doing in terms of prevention/wellness?

OTHER REMINDERS

- This is YOUR MONEY—spend it wisely.—Each carrier has on-line cost comparison.
- You own this account—not your employer—it will go with you wherever you go.
- Make sure you carry the debit card/checks with the health ID card.
- Utilize your preventive/wellness benefits annually.
- Check Wal-Mart, Sam's, Publix and Target for their discounts.
- Check MyFloridaRX.com for retail prices of drugs in your area.
- You will need to use your HSA debit card (and SHOW YOUR I.D. CARD) at the pharmacy—you will not be billed later as may be the case with your doctor.
- Check out the list of eligible expenses—while some don't apply to your health plan deductible, you can use HSA monies for many other medical, dental & vision expenses.
- As with anything, keep receipts and maintain a medical file!

FIGURING HSAS OUT FOR YOUR SITUATION

- How much did you spend on medical expenses last year (copays, deductible, Rx)?
- How much were your premiums for the year?
- What is the worst case scenario for a calendar year? What about the best case scenario?
- Keep in mind any pre-tax benefit or tax deduction and interest and possible investment options savings/earnings with your HSA.

HEALTH SAVINGS ACCOUNT TIPS

CONTRIBUTIONS

- In 2024, you may have a total annual deposit of $4,150 for individuals and $8,300 for individual + dependent(s) enrolled in the HSA plan.
- In 2025, you may have a total annual deposit of $4,300 for individuals and $8,550 for individual + dependent(s) enrolled in the HSA plan.
- Any amount funded in previous year and unused will be available for use in future years.
- If you are over 55, you can contribute an additional $1,000 each year

DETERMINING YOUR CONTRIBUTION

- Your eligibility to contribute to an HSA for each month is generally determined by whether you have a High Deductible Health Plan/HSA Compatible Plan (HDHP) on the first day of the month. If you or a dependent enroll in a non-HDHP, such as, Medicare, Veteran's Benefits or another health plan that does not qualify as the government's definition of an HSA compatible plan, you can no longer contribute to the HSA bank account. Your maximum contribution for the year is the greater of: 1) the full contribution, or 2) the pro-rated amount. The full contribution is the maximum annual contribution for the type of HDHP coverage you have times the number of months you have that type of coverage. If your contribution is greater than the pro-rated amount, and you fail to remain covered by an HDHP for the entire following calendar year, the extra contribution above the pro-rated amount is included in the income and subject to an additional 6 percent excise tax.
- Examples: If you first have family HDHP coverage on July 1, 2024, and keep HDHP coverage through December 31, 2024, you are allowed the full $8,300 family contribution to an HSA for 2024. If you fail to remain covered by an HDHP for all of 2024, $4,150 would be included in income and subject to an additional excise tax.
- If you have family HDHP coverage from January 1, 2024, until June 30, 2024, and have self-only HDHP coverage from July 1, 2024 to December 31, 2024, you are allowed an HSA contribution of 6/12 x $8,300 plus 6/12 of $4,150 or $6,225 for 2024.
- Contributions can be made as late as April 15th of the following year.

RESOURCES ONLINE

- US Treasury—http://www.treasury.gov
- HSA Educational: http://www.hsaed.com

YOUR HEALTH SAVINGS ACCOUNT MAY REIMBURSE

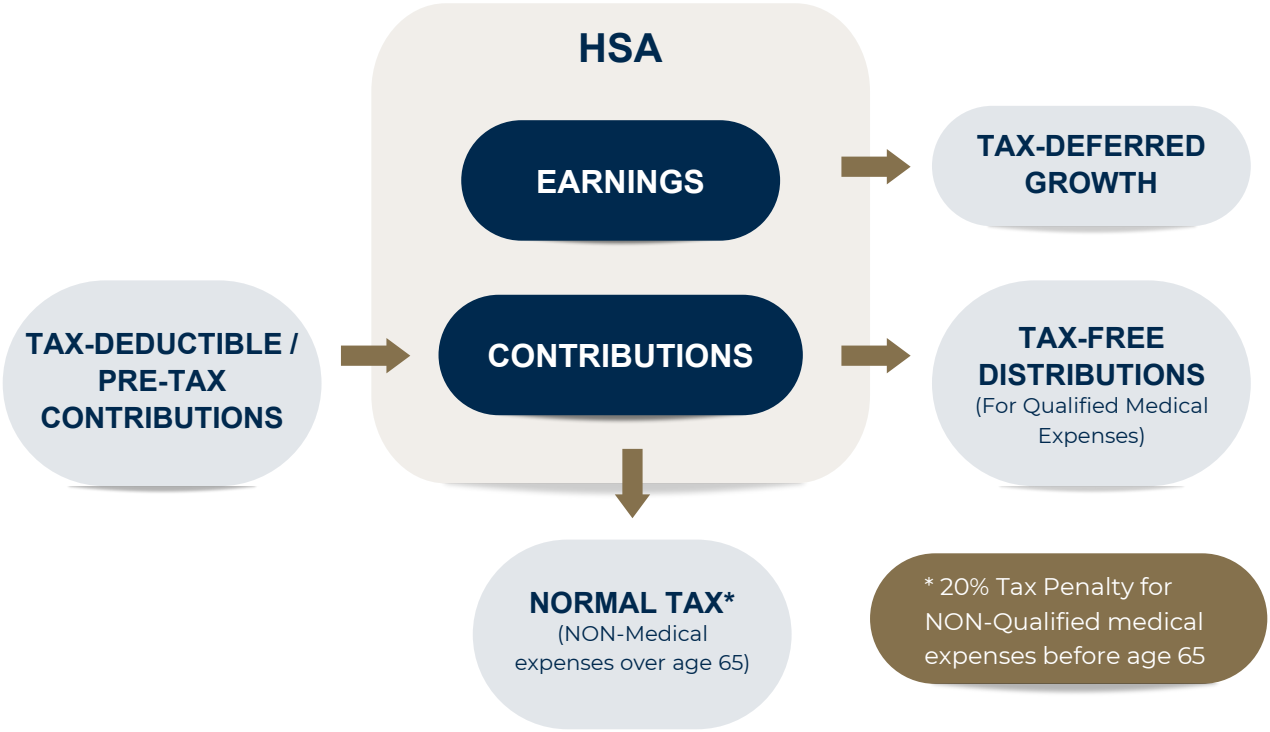
- Qualified medical expenses incurred by the account beneficiary and his or her spouse and dependents;
- COBRA premiums;
- Health insurance premiums while receiving unemployment benefits;
- Qualified long-term care premiums*; and
- Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals age 65 or older.
- Distributions from an HSA to reimburse the account beneficiary for eligible expense are excluded from gross income.

Please note that ONLY employees who enroll in the HSA-COMPATIBLE plan are eligible to open an HSA. Employees who enroll in the traditional copay plans are not eligible to open an HSA.

Also, you cannot simultaneously have a medical FSA and an HSA. If you elected a medical FSA for the prior plan year, you can only open an HSA on September 1st if your FSA balance is ZERO (meaning nothing can be left in the account during the grace period); if you have any FSA balance, you must wait until next year to open the HSA. The dependent care FSA is not tied to your medical plan or HSA.

Employees on Medicare cannot make or receive HSA contributions

TRIPLE TAX ADVANTAGE



HSA ELIGIBLE EXPENSES

- Abortion
- Acupuncture
- Alcoholism Treatment
- Ambulance
- Annual physical examination
- Artificial Limb
- Artificial Teeth
- Bandages
- Birth control pills
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment installed for a person with a disability
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Crutches
- Dental treatment (not including teeth whitening)
- Diagnostic Services
- Disabled Dependent Care Expenses
- Drug addiction treatment
- Eye Exam
- Eye Surgery
- Fertility enhancement (in vitro fertilization or surgery)
- Guide dog or other service animal
- Health institute fees (if treatment is prescribed by a physician)
- Certain health insurance premiums (not premiums for an employer-sponsored plan, but certain other medical premiums)
- Intellectually or developmentally disabled care, treatment or special home
- Laboratory fees
- Lactation expenses
- Lead-based paint removal (if child in the home has lead poisoning)
- Learning disability care or treatment
- Legal fees associated with medical treatment
- Lifetime care, advance payments or
- founder's fee"
- Lodging at a hospital or similar institution
- Long-term care
- Medical conference expense, if the conference concerns a chronic illness of yourself, your spouse or your independent
- Medical information plan
- Medications, if prescribed
- Menstrual products
- Nursing home fees
- Nursing services
- Operations
- Osteopath
- Oxygen
- Physical examination
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychologist
- Special education
- Sterilization
- Stop-Smoking Program
- Surgery
- Special telephone for hearing-impaired individual
- Television for hearing-impaired individuals
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Tuition for special education
- Vasectomy
- Vision correction surgery
- Weight-loss program if it is a treatment of a specific disease
- Wheelchair
- Wig
- X-Ray

Due to the COVID-19 pandemic of 2020 and the resulting CARES Act, over-the-counter medications are once again a TAX-FREE and allowable purchase using HSAs and FSAs.

(EMPLOYEE ONLY EXAMPLE)

HSA CALCULATOR

Fill out the below calculation table based on your specific medical needs:

FINANCIALS	HSA PLAN	COPAY PLAN
A. Annual Premium	$	$
B. Annual Deductible	$	$
C. Annual Max out of Pocket	$	$
D. Your usage last year	$	$
E. Your Rx copays	$	$
F. Pretax savings (determine your savings amt and tax bracket)		N/A
G. Company Contribution		
COST: Add A+D+E then subtract F & G	$	$

Example: The below example is based on a single employee without children that is deciding between a non-HSA and an HSA-compatible plan. This assumes 3 doctor visits per year (1 preventive; 1 primary and 1 specialist); as well as 2 ongoing Tier 2 prescription drugs.

FINANCIALS	HSA PLAN	HIGH PLAN
A. Annual Premium	$576	$1,956
B. Annual Deductible	$3,500	$1,500
C. Annual Max out of Pocket	$6,850	$4,500
D. Your usage last year (3 Drs: 1 is prev; 1 is PCP, 1 is spec)	$250	$85
E. Your Rx copays (Tier 2 x 2 monthly)	$1,248	$1,200
F. Pretax savings (assume $1500 contrib; 25% tax bracket)	-($375)	N/A
G. Company Contribution	-($1,200)	N/A
COST: Add A+D+E then subtract F & G	$499	$3,241

**SAVINGS OF $2,742

Remember to calculate your specific tax savings based on your annual contribution to the Health Savings Account and interest accrued on bank account. Also remember all qualified medical expenses will be tax free when paid for out of HSA.

(FAMILY EXAMPLE)

HSA CALCULATOR

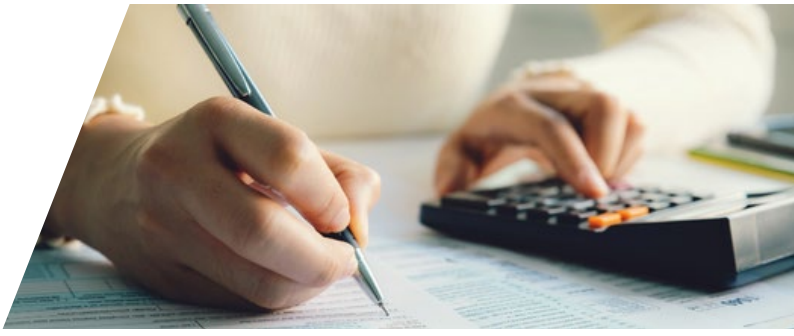
- Consider your own situation
- How much are you spending TODAY, as a payroll deduction for your CURRENT PLAN?
- If you switched to the HSA plan, covering the same dependents you do today, what would your payroll deduction become?
- Consider only placing THAT SAVINGS into the HSA bank account – remember, you own and control it; and it rolls over from one year to the next
- If you only contribute the savings from the new HSA plan premium over the premium you pay today, then you'll have NO additional money coming out of your paycheck.
- What are your out of pocket expenses for health care?
- What's your estimated overall savings, and what's your worst case scenario?

Example: The below example is based on an employee who is married with one child that is deciding between a non-HSA and an HSA-compatible plan. The example first compares annualized premiums; then assumes 3 doctor visits per year, per person (1 preventive/free, 1 primary sick visit, 1 specialist); then assumes 2 tier 2 prescriptions per person; and finally calculates HSA contributions and tax savings.

FINANCIALS	HSA PLAN	HIGH PLAN
A. Annual Premium	$3,284	$6,240
B. Annual Deductible	$7,000	$4,500
C. Annual Max out of Pocket	$14,000	$9,000
D. Your usage last year for 3 people (3 Drs: 1 is prev; 1 is PCP, 1 is spec)	$750	$255
E. Your Rx copays (Tier 2 x 2 monthly x 3ppl)	$3,744	$3,600
F. Pretax savings (assume contribute allowable max of $7200; 25% tax bracket)	-($1,800)	N/A
G. Company Contribution	-($1,200)	N/A
COST: Add A+D+E then subtract F & G	$4,778	$10,095

****SAVINGS OF $5,317**

Remember to calculate your specific tax savings based on your annual contribution to the Health Savings Account and interest accrued on bank account. Also remember all qualified medical expenses will be tax free when paid for out of HSA.



Teladoc HEALTH | Florida Blue

AVAILABLE NOW

You have access to clinicians anytime, anywhere*

We've added Teladoc Health to your benefits for when you need care for non-urgent and common conditions. Now, you can access clinicians by phone or video 24/7 from wherever you are.

Our U.S. board-certified clinicians help with conditions like the flu, bronchitis, rashes, sinus infections and more.

Talk to a clinician from wherever you are—day or night

Skip the trip to the ER or urgent care

Feel better when you need to.

Visit Teladoc.com
Call 1-800-TELADOC (800-835-2362)
Download the app

*Teladoc Health is not available internationally.

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18-057-V05 DEC 2018

Not all medications are alike - Know before you go to the pharmacy.

Find out…

- **Is my prescription drug covered?** If not, discounts may be available through our BlueSaver discount program.
- **Is this a generic drug?** Great! You're saving money.
- **Is an authorization required first?** If so, your doctor will need to submit a Prior Authorization form.
- **Is a limited quantity covered per prescription?** If so, your plan will cover up to the 1 month maximum, and you can pay for more.
- **Is this a brand name drug?** Ask your doctor or pharmacist if there's a generic available that's right for you.
- **Is this drug in the Step Therapy program?** If so, ask your doctor about the alternative drugs that must be tried first?
- **Is this an oral or injectible Specialty drug?** Specialty drugs require prior authorization and must be obtained through Caremark Specialty Pharmacy at 1-866-387-2573.
- **Is this a diabetic supply?** Supplies such as blood glucose testing strips and tablets, lancets, glucometers, and acetone test tablets and/or syringes require a prescription that you can fill at your local pharmacy.
- **Is this a drug that you take ongoing?** If your plan has mail order, order up to a 3-month supply and pay less than monthly refills at your local pharmacy.

Find participating pharmacies at **FloridaBlue.com**

Get answers…and compare drug costs based on your plan.

Call
a Care Consultant at **1-888-476-2227**.

Click
Log in at **FloridaBlue.com**. Select **Compare Drug Prices** under **Tools**

Step 1: Enter the drug name (or search by alphabet).
Step 2: Select pharmacies based on zip code.
Step 3: Compare prices and lower cost options, when available. Plus, see when Step Therapy, Prior Authorization or other requirements apply.

Visit
us in person at a **Florida Blue Center** near you. Visit **FloridaBlue.com** for locations.

72211 0514

FLEXIBLE SPENDING ACCOUNT

AMERIFLEX

Flexible Spending Accounts (FSAs) enable you to put aside money for important expenses and help you reduce your income taxes at the same time. The City offers two types of Flexible Spending Accounts—a Health Care FSA and a Dependent Care FSA. These accounts allow you to set aside pre-tax dollars to pay for certain out-of-pocket health care or dependent care expenses. Both plans are administered by Ameriflex.

HOW DO FSAs WORK?

Plan	Annual Maximum Contribution	Example of Covered Expenses
Health Care Flexible Spending Account	$3,200	Copays, deductibles, orthodontia, etc. *
Dependent Care Flexible Spending Account	$5,000 ($2,500 if married and filing separate tax returns)	Day care, nursery school, elder care expenses, etc. *

Each year during open enrollment, you decide how much to set aside for health care and/or dependent care expenses based on your projected costs for the year. Your contributions are deducted from your paycheck on a before tax basis in equal installments throughout the calendar year. As you incur health care expenses, you can either pay out-of-pocket and submit a claim form for reimbursement, or you can use your debit card to pay out-of-pocket and submit a claim for reimbursement. The debit card cannot be used for dependent care expenses.

**See IRS Publications 502 and 503 for a complete list of covered expenses at www.irs.gov/publications/p502*

WHAT IF YOU CURRENTLY HAVE AN FSA WITH FUNDS AND DECIDE TO MOVE TO THE HSA PLAN?

You cannot simultaneously have a traditional FSA and HSA; so the best option is to fully use all your FSA funds prior to opening the HSA account. Alternatively, you can move to a limited purpose FSA (dental/vision).

WHAT IF I HAVE MONEY LEFT OVER AT THE END OF THE YEAR?

You are able to rollover a maximum of $640 of remaining funds into plan year 2024-25.

WHAT IF MY EMPLOYMENT TERMINATES MID-YEAR?

You may submit a claim for reimbursement of eligible healthcare expenses which were incurred during the plan year of termination, as long as those expenses were incurred prior to the date of your termination within 30 days of last day worked. COBRA requirements may apply to the Health Care Spending Account.

You may submit a claim for reimbursement of eligible dependent care expenses incurred during the year, including expenses incurred after your termination date, against the balance in your account when you leave employment.

If you want to enroll in the Medical or Dependent FSA for 2024-25 plan year, you must complete a paper enrollment form and return to Human Resources by the 15th of the month prior to your election date. For example, 9/15/24 for annual open enrollment. Any current elections will not roll-over to the following plan year.

ENHANCED: VOLUNTARY ACCIDENT
METLIFE

With Accident Coverage, you receive benefits paid directly to you for unexpected accidents and injuries. You can utilize the payment any way that you choose, to help cover-day-to day living expenses or any other expenses not covered by your medical plan.

From simple things like bee stings or poison ivy, to more common things like broken bones or torn tendons, and even major events like a car accident where you may land in the hospital, Accident Coverage allows you to cover your out-of-pocket risks if and when OFF THE JOB injuries or accidents occur.

Immediate Value	Pays $100 annually for a recognized wellness screening (1x per CY)
Benefit Highlights	• Emergency Care Benefit pays: $200 for Emergency Room, Physician's Office or Urgent Care Visit (combined with non-emergency initial care) • Non-Emergency Initial Care Benefit pays: $100 (1x per accident) • Physician Follow-up visit pays: $100 (2x per accident; 6x per CY) • Pays $1,500 when admitted to the Hospital, plus $400/day for confinement, up to 15 days (payable after the first day of admission). • Pays $3,000 when admitted to the ICU, plus $800/day for ICU confinement (ICU confinement pays in addition to hospital confinement, up to 15 days) • Pays up to $8,000 for broken bones and up to $3,000 for dislocations. • Organized Sports Injury Benefit pays: an extra 25% of eligible benefits • Pays for torn tendons, ligaments, rotator cuff, knee cartilage, wheelchair/crutches, CT/MRIs, physical therapy, and much more! • Includes a Basic Accidental Death policy of $100,000 for Employee, $50,000 for Spouse and $20,000 for Child(ren) covered on the policy.
Bi-Monthly (24) Payroll Deductions: PRE-TAX	Employee $5.86 Employee + Spouse $13.38 Employee + Child(ren) $16.39 Family $21.48

ENHANCED: CRITICAL ILLNESS
METLIFE

With Critical Illness coverage, you receive benefits paid directly to you when you are diagnosed with a covered illness. You can utilize the payment any way that you choose, to help cover day-to-day living expenses or any other expenses not covered by your medical plan.

A major illness such as a Heart Attack, Stroke or Invasive Cancer can leave you overwhelmed, both emotionally and financially. Critical Illness Insurance can relieve the financial and emotional impact of an illness so you can focus on recovery.

Immediate Value	Pay $100 Employee; $100 Spouse; annually for a recognized wellness screening
Highlights	• Employees may choose a lump sum benefit of $10,000 or $20,000 Guaranteed Issue - $20,000 (No medical questions) • Spouse and Child(ren) will be offered 50% of the Employee benefit amount. • Premiums are Attained Age and will change as the insured ages. • Employee, Spouse and Child premiums are based on Employee's age, benefit amount and tobacco usage. • No Pre-existing condition limitations • Second occurrence pays 50% of Initial benefit for specified illnesses.
Benefits	• Plan pays 100% of benefit amount if diagnosed with: Benign Brain Tumor, Invasive Cancer, Loss of Hearing/Sight/Speech, Paralysis (2 limbs), Kidney Failure, Major Organ Transplant, Burns, Coma, Stroke, or Progressive diseases such as ALS, Alzheimer's Disease, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease. • Plan pays 75% of benefit amount if diagnosed with Benign Brain Tumor • Pays 50% of benefit amount if diagnosed with Coronary Artery Bypass, Sudden Cardiac Arrest • Pays 5% (not less than $250) for Skin Cancer • Plan pays 100% for specified Childhood Diseases • Plan pays 25% of benefit amount if diagnosed with: Non-Invasive Cancer • Infectious Diseases also payable at 25%, include Bacterial Cerebrospinal Meningitis, Diphtheria, Encephalitis, Legionnaire's Disease, Malaria, Necrotizing Fasciitis, Osteomyelitis, Rabies, Tetanus, Tuberculosis

ENHANCED: CRITICAL ILLNESS
METLIFE

Bi-Monthly (24) Payroll Deductions				
Non-Tobacco $10k / $20k				
EE Age	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
<25	$2.60 / $5.20	$4.95 / $9.90	$4.90 / $9.80	$7.25 / $14.50
25-29	$2.70 / $5.40	$5.15 / $10.30	$4.95 / $9.90	$7.40 / $14.80
30-34	$3.15 / $6.30	$5.90 / $11.80	$5.45 / $10.90	$8.20 / $16.40
35-39	$3.85 / $7.70	$7.05 / $14.10	$6.20 / $12.40	$9.35 / $18.70
40-44	$5.15 / $10.30	$9.05 / $18.10	$7.45 / $14.90	$11.40 / $22.80
45-49	$7.00 / $14.00	$12.10 / $24.20	$9.30 / $18.60	$14.40 / $28.80
50-54	$9.35 / $18.70	$16.10 / $32.20	$11.70 / $23.40	$18.40 / $36.80
55-59	$12.45 / $24.90	$21.40 / $42.80	$14.75 / $29.50	$23.70 / $47.40
60-64	$17.40 / $34.80	$29.75 / $59.50	$19.75 / $39.50	$32.10 / $64.20
65-69	$25.45 / $50.90	$43.20 / $86.40	$27.75 / $55.50	$45.55 / $91.10
70+	$38.65 / $77.30	$64.30 / $128.60	$40.95 / $81.90	$66.65 / $133.30

Bi-Monthly (24) Payroll Deductions				
Tobacco $10k / $20k				
EE Age	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
<25	$3.00 / $6.00	$5.50 / $11.00	$5.30 / $10.60	$7.85 / $15.70
25-29	$3.15 / $6.30	$5.80 / $11.60	$5.45 / $10.90	$8.10 / $16.20
30-34	$4.00 / $8.00	$7.15 / $14.30	$6.30 / $12.60	$9.45 / $18.90
35-39	$5.20 / $10.40	$9.15 / $18.30	$7.50 / $15.00	$11.45 / $22.90
40-44	$7.40 / $14.80	$12.70 / $25.40	$9.75 / $19.50	$15.05 / $30.10
45-49	$10.75 / $21.50	$18.10 / $36.20	$13.10 / $26.20	$20.40 / $40.80
50-54	$15.00 / $30.00	$25.15 / $50.30	$17.35 / $34.70	$27.45 / $54.90
55-59	$20.45 / $40.90	$34.55 / $69.10	$22.75 / $45.50	$36.85 / $73.70
60-64	$29.20 / $58.40	$49.50 / $99.00	$31.55 / $63.10	$51.85 / $103.70
65-69	$43.55 / $87.10	$73.65 / $147.30	$45.90 / $91.80	$75.95 / $151.90
70+	$67.30 / $134.60	$111.40 / $222.80	$69.60 / $139.20	$113.70 / $227.40

ENHANCED: HOSPITAL SELECT
METLIFE

With Hospital Select coverage, you receive benefits paid directly to you for unexpected hospital admissions and confinement. You can utilize the payment any way that you choose, to help cover day-to-day living expenses or any other expenses not covered by your medical plan.

When you are admitted to the hospital, medical out-of-pocket expenses can be alarming and cause undue strain on you emotionally and financially. Hospital Indemnity coverage can reduce this strain on you and your family and allow you to focus on recovery. The policy covers you for any reason that you are admitted to the hospital, including major surgery and sickness as well as bringing a new baby into the world. Coverage is Guaranteed Issue for you and your dependents, with pre-existing conditions (anything diagnosed or treated in previous 12 months cannot be cause of hospitalization for the first 12 months of the policy).

Benefit Highlights	• $1,500 Initial Hospitalization Benefit (4x per calendar year) • $300 per day confinement in the hospital (up to 15 days) • $300 per day confinement in the ICU (benefit paid concurrently with the hospital confinement benefit) (up to 15 days) • $150 per day of in a rehabilitation unit. (max 15 days per accident not to exceed 30 days per calendar year.) • $75 per day (up to 2 days) Newborn Nursery Care
How the Plan Works	If you are admitted to the hospital for removal of your Gall Bladder and spend 3 days in hospital confinement. • Initial Hospitalization: $1,500 • Hospital Confinement 3 days x $300 = $600 (if admission benefit is payable for a confinement, the confinement benefit will begin to be payable the day after admission). Initial Benefit paid to you: $2,100
Bi-Monthly (24) Payroll Deductions: PRE-TAX	Employee $14.19 Employee + Spouse $29.16 Employee + Child(ren) $24.25 Family $41.64

ENHANCED BENEFITS
METLIFE

TWO SIMPLE STEPS TO FILE YOUR CLAIM

Step 1 – Confirm your Plans and Options for Benefit Payments

Call the MetLife Claims Customer Service Center for claims and policy details at 1-800-Get-Met8 or 1-800-438-6388. They are open Monday – Friday from 8:00 A.M. to 8:00 P.M. Eastern Standard Time or visit the MetLife website at www.mybenefits.metlife.com

The MetLife Claims Customer Service Center will provide you with the claim forms and instructions on where to send the forms and required supporting documents.

Here are examples of the types of supporting documents you may need. Ask the Claims Customer Care Center which documents you need to provide them for your specific claim:

1. EOBs – Explanations of Benefits – these come from your medical or dental carrier
2. Copy of Lab or X-ray reports
3. Proof of the injury/ medical equipment required
4. UB04 if hospitalized due to accident
5. If transported by ambulance – ambulance bill
6. If this was due to a car accident – incident or police report

Step 2 - Submit your Claim Direct to Carrier

There are multiple ways to submit your claims. You can call, visit the website or download the MetLife Mobile App to view your certificate of insurance and initiate your claim.

The fastest way to submit your claim is online: www.mybenefits.metlife.com

How to Get Your Money:

- Once your claim is approved, you'll receive a check made out to you to use however you like.

What if I called Customer Care Center about my claim and I still need help, who do I call?

- For escalated claims concerns you can contact your Alltrust Account Manager.

DENTAL INSURANCE

METLIFE

	DHMO	PPO	
Services Include	In-Network ONLY	In-Network	Out-Of-Network
Deductible	None	$50 Individual $150 Family	$50 Individual $150 Family
Preventive Services Routine exams, Cleanings, X-Rays, Fluoride, etc.	Copays - $5 Office Visit	Covered at 100% (no deductible)	Covered at 100% (no deductible)
Basic Services Filings, Simple extractions, Oral Surgery, Endo, etc.	Copays	Covered at 80% after Deductible	Covered at 80% after Deductible, + any balance over the Usual & Customary Charge
Major Services Inlays, onlays, dentures, implants, surgical extractions, Perio, etc.	Copays	Covered at 50% after Deducible	Covered at 50% after Deductible, + any balance over the Usual & Customary Charge
Maximum Annual Benefit Per Person Covered	None	$1,000	
Orthodontia	Discount Available	Not Included	

Dental Bi-Monthly (24) Payroll Deductions – PRE-TAX		
	DHMO	**PPO**
Employee	$5.35	$12.97
Employee + 1	$9.37	$26.00
Employee + Family	$13.82	$41.19

FREQUENCY AND AGE LIMITS APPLY TO CERTAIN SERVICES.

For example, the plan includes coverage for up to two routine cleanings per year and one set of bitewing x-rays per year. Coverage for fluoride treatments is included once per year for dependent children through age 13. Coverage for sealants is included once per lifetime for dependent children through age 13. Additional restrictions are outlined in the Certificate of Coverage.

DENTAL INSURANCE
METLIFE

HOW TO FIND AN IN-NETWORK DENTIST

- Go to www.metlife.com
- Click “Find a Dentist”
- Choose your Network
  - “Dental HMO/ Managed Care” for MET290
  - “PDP Plus” for MetLife PPO
- Enter your “zip code, city, or state”
- Click “Find a Dentist”

REMEMBER!

Always ask your Dentist to submit a pre-determination of coverage prior to having any service over $300.

What Provider Network do I use?	**DHMO: Dental HMO/ Managed Care** **PPO: PDP Plus**
Do I need to choose a Dentist?	DHMO: Yes PPO: No, you may see any Dentist. However, you will make the most of your plan by choosing an In-Network Dentist.
Do I need a referral to see a Specialist?	No
Can I go Out-Of-Network?	DHMO: No PPO: Yes. However, Out-Of-Network providers are paid based on Usual & Customary (U&C) Charges, which may be less than your Out-Of-Network provider charges. You are responsible to pay the difference to the Out-Of-Network provider.
Will I get an ID Card?	No, ID cards are not issued for Dental. Your provider will verify your benefits with your Social Security Number.

USUAL & CUSTOMARY CHARGES

This refers to the base amount that is treated as the standard or most common charge for a particular dental service when rendered in any given geographic area. When accessing care Out-Of-Network this is the amount on which the claim will be paid. You are responsible to pay the difference in the provider’s actual charge and what the insurance reimburses.

PREDETERMINATION OF BENEFITS

This optional service provides you with an estimate on the amount to be covered prior to having a dental procedure. When your treatment plan is expected to exceed $300, ask your Dentist to request the Predetermination Review. Your Dentist will submit your treatment plan and the insurance carrier returns an estimate of what they expect to pay and what you can expect to pay.

MAXIMUM ANNUAL BENEFIT

This is the most the insurance carrier will pay for covered services in a calendar year. You are responsible for any additional charges during that calendar year once the benefit has been exhausted.

VISION INSURANCE
METLIFE

	FREQUENCY LIMITS	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE
Eye Exam	**Covered once every 12 months**	$10 Copay	Covered up to $45 allowance
Eyeglass Lenses	**Covered once every 12 months**	$15 Copay	Covered up to allowance: $30 Single $50 Bifocal $65 Trifocal $100 Lenticular
Traditional Eyeglass Frames	**Covered once every 24 months**	$100 allowance 20% off amount over allowance	Covered up to $55 allowance
Contact Lenses	**Covered once every 12 months instead of lenses and frames**	Elective: $100 allowance Medically Necessary: $15 Copay	Elective: Covered up to $80 allowance Medically Necessary: Covered up to $210 allowance

Vision Bi-Monthly (24) Payroll Deductions – PRE-TAX

	VISION PLAN
Employee	$2.77
Employee + 1	$5.29
Employee + Family	$8.60

HOW TO FIND AN IN-NETWORK VISION PROVIDER

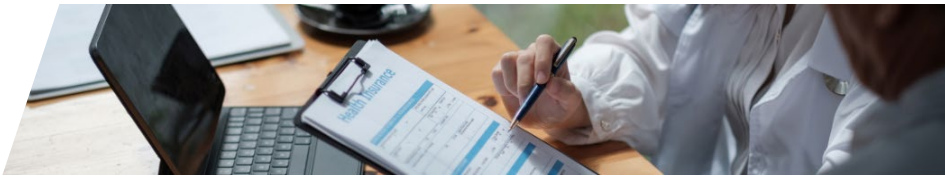
- Go to www.metlife.com
- Click “Find a Vision Provider”
- Enter your “zip code, city, or state”

What Provider Network do I use?	**Vision PPO**
Can I go Out-Of-Network?	Yes. However, when using Out-Of-Network providers you will need to pay full price at the time of service and then submit a claim to MetLife for reimbursement up to the plan allowances.
Will I get an ID card?	No, ID cards are not issued for Vision. Your vision provider will verify your benefits with your Social Security Number and DOB.
How do the Frequency Limits work?	The frequency limits are based on your last date of service while insured under this plan. For example, if you had an eye exam and frames & lenses on 5/10/2023, they would be eligible for an eye exam and lenses on 5/11/2024 if you are still enrolled in the plan.
Can I add features to my lenses?	Yes. Additional Glasses and Sunglasses: 20% off additional glasses and sunglasses

BASIC LIFE AND AD&D INSURANCE
METLIFE

EMPLOYER PAID LIFE AND AD&D

As a benefits eligible employee, our company provides you with a Basic Life and AD&D policy at no cost to you!



BASIC LIFE AND AD&D	
Basic Life Benefit	$10,000
AD&D Benefit	$10,000
Benefit Reduction	The benefit amounts shown above will reduce by 35% at age 65, by 60% at age 70, and by 80% at age 75
Conversion	Upon termination of employment this policy may be converted to an individual policy. Please contact the carrier as soon as your employment ends to begin this process. You must apply and to the carrier within 31 days of your termination to exercise the conversion option.
Payroll Deductions	Provided to eligible employees at no cost to you

IMPORTANT

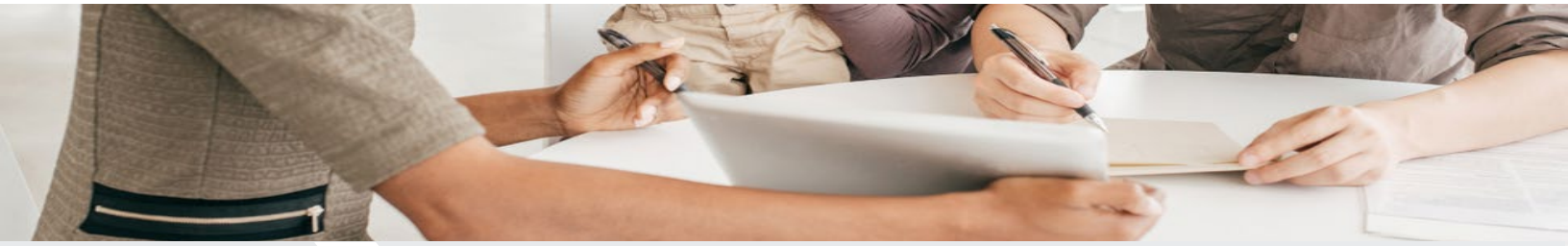
Please be sure to name a Beneficiary when making your elections. You may name more than one if desired.

PRIMARY BENEFICIARY

The person or people that will receive the benefit upon your death. You name the beneficiary at the time of enrollment. You may also change your beneficiary at any time

SECONDARY BENEFICIARY OR CONTINGENT BENEFICIARY

The person or people that will receive the benefit upon your death ONLY if there is no living Primary Beneficiary at the time of your death.



VOLUNTARY LIFE INSURANCE
METLIFE

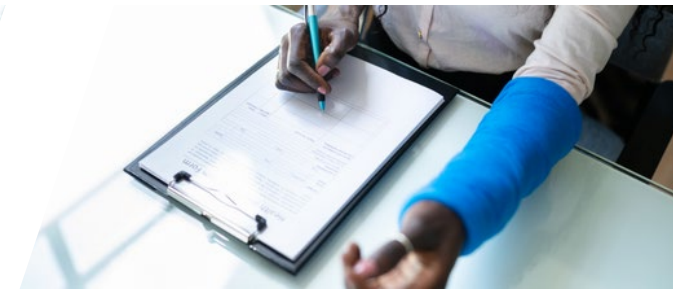
You can elect additional life insurance coverage for you, your spouse, and your dependent children. You must enroll in this coverage in order to elect coverage for your dependents. If you do not elect coverage when you are initially eligible, you will have to complete an Evidence of Insurability form for underwriting review & approval before any coverage is issued.

	EMPLOYEE COVERAGE	SPOUSE COVERAGE	DEPENDENT CHILD COVERAGE
Available Increments	$10,000	$5,000	$1,000
Coverage Maximum	7 times your pay or $500,000, whichever is less	50% of the employee coverage amount or $100,000, whichever is less	$10,000 Ages 6 months to the child's 26th birthday
Guarantee Issue Amount	Newly eligible employees may elect up to $150,000 without Evidence of Insurability	Elect up to $50,000 on your newly eligible Spouse without Evidence of Insurability.	Elect up to $10,000 on your newly eligible dependent children without Evidence of Insurability
Future Increase Option	If you waive coverage when you are newly eligible, you will be required to submit EOI if you add or increase your election(s) by more than one increment or if your election(s) are above the guaranteed issue amount. All Spouse election changes require submission of EOI.		
Additional Features	Accelerated Death Benefit You can receive a portion of your term life insurance cash benefit if you are diagnosed with a terminal illness. This is also known as a living benefit. Your coverage amount is then simply reduced by the amount you receive. Premium Waiver You won't have to pay your life insurance premium if you become totally disabled for six months or longer prior to age 60. Conversion You can convert your group coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. To take advantage of this benefit, send your written application and first premium payment to MetLife within 31 days of the date your coverage would otherwise end. Portability You may be able to continue your coverage if you leave your job. To take advantage of this benefit, send your written application and first premium payment to MetLife within 31 days of the date your coverage would otherwise end.		

EVIDENCE OF INSURABILITY (EOI)

A Medical questionnaire referred to as an Evidence of Insurability (EOI) Form is required if you (1) are a newly eligible employee or spouse electing an amount over the Guarantee Issue Limits, (2) you are adding or increasing your coverage during the annual enrollment. When EOI is required the insurance company will decide if your request will be approved. Amounts subject to EOI will not begin unless/until approved by the insurance company.

LONG TERM DISABILITY INSURANCE
METLIFE



Being financially secure doesn't just mean planning for retirement. A serious disability or accident can cause a real financial hardship, especially if your family depends on your income. Long Term Disability Insurance is intended to provide you with income replacement if you are unable to work due to an off-the-job accident or illness and are under the care of a doctor.

Benefits Begin	On the 181st day you are disabled.
Benefit Amount	The plan pays you 60% of your monthly income, to a maximum of $5,000 per month.
Maximum Payment Period	Maximum duration is to Social Security Normal Retirement Age with Reducing Benefit Duration.
Pre-Existing Condition Limitation	If you become disabled during the first twelve months you are enrolled in the plan that was due to a pre-existing condition it won't be covered. A pre-existing condition is a condition/symptom that you were treated for, consulted with a physician, or took prescribed medications in the 6 months immediately prior to your effective date. The plan will cover expenses during this period that are not related to a pre-existing condition. Claims incurred after you have been enrolled in the plan for 12 months due to a pre-existing conditions will also be covered.

Monthly Contribution Worksheet

Step 1: My gross annual salary is $ _____

Step 2: My gross monthly salary is:

$ _____ Divided by 12 = $ _____

Step 3: My monthly contribution amount is:

$ _____ Divided by $100 = $ _____

Gross Monthly Salary

Multiply by Age Rate = $ _____

Monthly Contribution

SHORT TERM DISABILITY INSURANCE
METLIFE

Short Term Disability Insurance is intended to provide you with temporary income replacement if you are unable to work due to an off-the-job accident or illness and are under the care of a doctor.

Benefits Begin	On the 1st day for accidents and the 8th day for sickness.
Benefit Amount	The plan pays you up to 60% of your weekly income, to a maximum of $1,000 per week.
Payment Lasts	The plan will continue to pay you for up to 26 weeks if you remain disabled. This will coordinate with LTD coverage.
Pre-Existing Condition Limitation	Any Short Term Disability claim filed during the first 12 months of coverage are subject to the pre-existing condition lookback period of 3 months prior to the effective date of coverage.

Monthly Contribution Worksheet

Step 1: My gross annual salary is $ _____
Gross Annual Salary

Step 2: My gross weekly salary is:
$ _____ (Gross Annual Salary) Divided by 52 = $ _____ (Gross Weekly Salary)

Step 3: My benefit is:
$ _____ (Gross Weekly Salary) Multiply by 60% = $ _____ (Weekly Benefit)

Step 4: My Premium is:
$ _____ (Weekly Benefit) Divided by $10 = $ _____

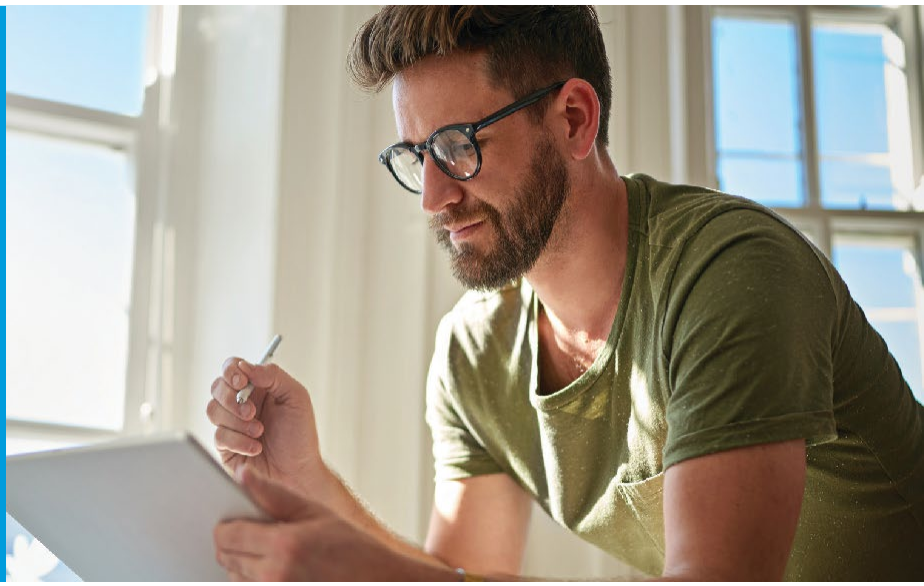
Step 5: Multiply by $0.607 = $ _____
Monthly Cost

* Please note if your salary exceeds the maximum, use the maximum weekly.

Professional support and guidance for everyday life

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward.

We can help you and your family, those living at home, get professional support and guidance to make life a little easier. Our Employee Assistance Program (EAP) is available to you in addition to the benefits provided with your MetLife insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life — at no additional cost to you.



Help is always at your fingertips.

Our mobile app makes it easy for you to access and personalize educational content important to you.

Search "TELUS Health" on iTunes App Store or Google Play. Log in with the user name: **metlifeeap** and password: **eap**

Expert advice for work, life, and your well-being

The program's experienced counselors provided through TELUS Health — one of the nation's premier providers of Employee Assistance Program services — can talk to you about anything going on in your life, including:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Convenient and confidential help when you want it, how you want it

Your program includes up to 5 phone or video consultations with licensed counselors for you and your eligible household members per year. You can call **1-888-319-7819** to speak with a counselor or schedule an appointment, 24/7/365.

When you call, just select "Employee Assistance Program" when prompted. You'll be connected to a counselor.

If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a consultant to guide you to the information you are looking for or help you schedule an appointment with a counselor.

Log on to one.telushealth.com, user name: metlifeeap and password: eap

MetLife

Navigating life together

Answers to important questions

Are Employee Assistance Program services confidential?
Yes. Any personal information provided to TELUS Health stays completely confidential.*

How do I get help?
Getting professional help is just a phone call away. Simply call 1-888-319-7819 to speak with a counselor or to schedule a phone or video conference appointment. These services are available 24 hours a day, 7 days a week.

When is the right time to call?
That's up to you. Counselors are here whenever you need them —whether you simply need to talk or want guidance on something you are going through.

Does the program have any limitations?
While we offer a broad range of services, we may not cover all services you may need. Your Employee Assistance Program does not provide:

- Inpatient or outpatient treatment for any medically treated illness
- Prescription drugs
- Treatment or services for intellectual disability or autism
- Counseling services beyond the number of sessions covered or requiring longer term intervention
- Services by counselors who are not TELUS Health providers
- Counseling required by law or a court, or paid for by Workers' Compensation

Does the program offer Cognitive Behavioral Therapy (CBT)?
Many TELUS Health EAP providers are trained in this type of counseling and the foundation of TELUS Health' CareNow digital programs, available through the programs website and mobile app, are built upon Cognitive Behavioral Therapy (CBT) techniques. CareNow provides instant access to a range of self-service programs developed by world leading experts, focused on behavior change in the areas of anxiety, stress, depression, and more.

When you need some support, we're here to help.

Phone
1-888-319-7819

Web
one.telushealth.com
user name: metlifeeap
and password: eap

Mobile App
user name: metlifeeap
and password: eap

*MetLife and TELUS Health abide by federal and state regulations regarding duty to warn of harm to self or others. In these instances, the consultant may have a duty to intervene and report a situation to the appropriate authority.

MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

Grief Counseling

Employer Reference Guide

Grief counseling services are offered with MetLife's life insurance coverage. Whether it's help coping with a loss or a major life change, the professional counselors and services we offer through TELUS Health, are ready to support you, your employees and their families to move forward.1

Confidential 24/7 support for employees

Call **1-888-319-7819** or visit **one.telushealth.com**
User Name: **metlifeassist**
Password: **support**

Professional support for when:

- a loved one has died
- a divorce is finalized
- a serious medical diagnosis or critical illness has occurred
- a layoff or termination of a job has occurred

These counseling sessions are tailored to help meet individual needs. Up to 5 in-person or telephonic sessions are available with a licensed TELUS Health counselor.

Confidential legal and financial consultation

- Access to a TELUS Health in-house attorney for a 30 minute consultation to assist with making informed decisions as it pertains to a loss
- 1hour consultation with a certified financial planner to assist with education, strategies and options

Resources available

TELUS Health offers online, self-help resources to assist with the grieving process, providing support for:

- End-of-life issues
- What to do after the death of a loved one
- Dealing with grief

Funeral assistance services

Through private sessions, counselors can help employees, their loved ones and beneficiaries with funeral arrangements. They can provide referrals and helpful information about:

- Nearby funeral homes and cemetery options
- Funeral cost estimates from local providers
- Service providers such as florists, caterers and hotels
- Funeral and memorial planning
- Adult care for surviving elders
- Dealing with becoming a single parent
- Back-up care for children or elderly
- Notifying the Social Security Administration, banks, and utilities
- Local support groups

TELUS Health onsite support services for employers

A comprehensive trauma management service provided by specially trained consultants is available 24/7, 365 days a year via the TELUS Health toll free line. Critical Incident Stress Management (CISM) services include:

- Management consultation
- Coordination for onsite critical incident response for events* including:
  - sudden death
  - anticipatory grief
  - workplace violence/accidents/disasters
  - natural disasters
- Standard response time is within 24 hours. Rapid response or extra services are available at an additional cost.

*Up to 4 hours per incident at one location.

Request onsite support in three simple steps

Step 1

Call TELUS Health toll-free at **1-888-319-7819** to request onsite support.

Step 2

A TELUS Health Service Advisor will gather preliminary information, including:

- Company name
- Demographic information (e.g. – name, contact number(s), email address, role)
- Nature of the incident

Step 3

You will be connected to a specialty team member for further assessment. In cases where an immediate transfer cannot be made, a callback will be scheduled for within 20 minutes.

Services Rate Schedule

Additional services are available by request at the rates listed below.

Service Description	Rate	Billing Event
CISM – Rapid Response within 2 hours of request	$315.00	Per Hour
CISM – Standard Response within 24 hours of request for additional counselors and/or locations (2 hour minimum)	$230.00	Per Hour

Get expert guidance for confident decisions.

Contact your MetLife representative today.

1. Grief Counseling and Funeral Assistance services are provided through an agreement with TELUS Health. TELUS Health is not an affiliate of MetLife, and the services TELUS Health provides are separate and apart from the insurance provided by MetLife. TELUS Health has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms. MetLife Group Term Life insurance is issued by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166 under Policy Form PN99/G2130-S.

   Nothing in these materials is intended to be advice for a particular situation or individual. Please consult with your own advisors for such advice. Like most group insurance policies, insurance policies offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact your benefits administrator or MetLife for costs and complete details.

metlife.com

CONTACTS

Carrier / Vendor	Phone / Email	Website
Florida	Medical: 877-352-2583	www.floridablue.com
MetLife	Dental: 800-942-0854 Vision: 855-638-3931 Life: 800-523-2894 Disability: 800-858-6506	www.metlife.com
Ameriflex	FSA: 888-868-3539	service@myameriflex.com
GIS	Benefits Connect: 866-400-7771	patraservice@gisbenefits.net
Acrisure	727-772-4214 Sandy Harrington; Account Manager sharrington@acrisure.com 727-772-4221 Michelle Urso; Account Executive murso@acrisure.com 727-772-4212 Corey Lilburn, CEBS, CSFS; Managing Partner clilburn@acrisure.com	www.acrisure.com/southeast
Personal Lines – Home and Auto Insurance	352-818-6198 Karyn Halstead KHalstead@acrisure.com	

DISLAIMER

This guide and presentation is only intended to offer an outline of benefits. All details and contract obligations of plans are stated in the group contract/insurance documents, including any disclosures (whether regarding "grandfathering" of plans or others) required by the healthcare reform law, the Patient Protection and Affordable Care Act (PPACA). In the event of a conflict between this guide and the group contract/insurance documents, the group contract/insurance documents will prevail. Please contact your Human Resources Department for further information.

INFORMATION PROVIDED BY

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The information contained herein is intended to serve only as a brief outline of the various insurance coverages. To avoid misunderstanding or misinterpretation as to the full scope of protection afforded, reference must be made to the respective policies for complete coverage details.