2018 Per Diem Employee Benefits Guide

Sarasota Memorial Health Care System offers an inclusive, flexible compensation and benefits package to help you take care of yourself and your family. We're committed to providing the most comprehensive benefits possible, at costs that are reasonable for you and the health system.

This guide highlights the information you will need to make your choices. Please set aside time to read these materials, share them with your family and choose the combination of benefits that's right for you. Detailed information regarding our health plans is available in the "Sarasota Memorial Health Care System Health and Wellness Plan Summary Plan Description" and in our "Summary of Benefit Coverage". These documents are available on Pulse (the SMHCS intranet site) or on the internet at www.gulfcoastmemberservices.org and www.webtpa.com. If you prefer a paper or email copy of these documents at no cost to you, please contact Human Resources by email at HRServiceCenter@smh.com, or call our HR Service Line at 941-917-6177.

The benefits reviewed in this Guide are effective October 1, 2017.

YOU CAN FIND INFORMATION ABOUT	ON PAGE
Highlights of the Benefits Program	2
Benefit Options Overview	4
Medical Plans	4
Medical Plan Comparison Chart	6
Prescription Drug Coverage	8
Prescription Drug Plan Comparison Chart	9
Employee Assistance Program (EAP)	11
Voluntary Benefits	12
Where to Get Help	12

Note: This enrollment guide summarizes the key features of the Benefits plan. Complete information can be found in the official plan documents, which define and govern the actual benefits. In the event there is an inconsistency between this summary and the actual plan documents, the actual provisions of the Plan will govern. Sarasota Memorial Health Care System may change these benefits at any time. Plan provisions and eligibility for coverage do not constitute a contract of employment with any individual.

HIGHLIGHTS OF THE BENEFITS PROGRAM

CHOOSE COVERAGE UNDER THESE PLANS

The Benefit program offers choices in these areas:

- Medical
- Pharmacy

WHO CAN ENROLL

Any per diem employee who has worked an average of 30 or more hours over the past year will qualify for a limited benefit package.

FAMILY COVERAGE

Under your family coverage election available under most plans, you may enroll your eligible dependents in the plan. For this purpose, eligible dependents for the Medical Plan include your children under age 26. Children include your natural and adopted children and certain other children who depend on you for support, such as stepchildren or foster children. Grandchildren, nephews, nieces and other children with extended relationships to you are not eligible for coverage even if they depend on you for support. Proof of Relationship and social security numbers are required for all dependents.

EXTENDED OVER-AGE FAMILY COVERAGE

Pursuant to Florida law, you may separately enroll children who do not qualify for coverage under your family coverage under some circumstances. The enrollment of any child separate from your family coverage will require payment of a separate premium for that child by you. Under current tax laws, the payment for over-age coverage cannot be made on a pre-tax basis through SMHCS's payroll system. Contact the HR Department to enroll the child and make arrangements for payment of these benefits for your over-age dependents. The cost of enrolling a child that qualifies for this extended over-age family coverage will be the COBRA cost that would apply to purchase single person coverage under COBRA.

A child is eligible for extended over-age family coverage if the child is not eligible to be covered under your family coverage and the child falls with the following categories:

- The child is age 26-30 and is unmarried with no dependents of his/her own and either (i) lives in Florida, or (ii) is a full or part-time student.

If you have a child who does not qualify for enrollment under regular family coverage but does qualify for enrollment under the extended over-age family coverage, you may enroll that child. If a child enrolls in over-age family coverage and then stops coverage, he/she will only be eligible to re-enroll again if he/she continues to meet the requirements above and he/she, as of the re-enrollment date, has not had a 63 day break in coverage that would be considered a break in creditable coverage. Your child will continue to be eligible for the extended over-age family coverage until the last day of the calendar year in which he/she is eligible, or until the date that he/she no longer meets the eligibility criteria described above.

PROOF OF RELATIONSHIP

Proof of Relationship is required to enroll all Dependents. Acceptable Proof of Relationship documents are:

- For All Dependents:
  - First page of your most recent Federal Tax Return (Form 1040) listing the name and social security number of your spouse and/or all children you will enroll in SMHCS healthcare plan (please black out all financial data).

If this form lists all of the dependents you will enroll in your SMHCS healthcare plan, it is the only document you will need to provide. Alternatively, you may provide:

- For dependent children under age 26:
  - Birth Certificate

- For unmarried dependent children age 26 and older:
  - Birth Certificate and a copy of the current full- or part-time School Schedule
  - Physician's Certification for disabled children

You must notify the Human Resources Department of any change in your dependents' status that would affect the dependents' eligibility for continued coverage. Your notice of the change must be delivered to the Human Resources Department within 30 days of the date of the change.

PAYING FOR YOUR BENEFITS

SMHCS subsidizes a large portion of the cost of your benefits. You are able to figure your per-pay-period benefit costs from your online enrollment.

You pay for premiums with before-tax contributions. Those contributions will be deducted from your pay throughout the year. When you use before-tax contributions to pay for benefits, you save money in taxes. You do not pay federal or Social Security tax on before-tax contributions.

WHEN IS MY INSURANCE EFFECTIVE?

Benefits are available to per diem employees when they average 30 or more hours per week over a year's time.

CHOOSE ONCE A YEAR

The choices you make now will remain in effect through September 30. Once you make your elections, they stay in effect for the entire year. However, if you have an eligible change in status during the year, you may change your elections consistent with the change in status.

LIMITED CHANGES DURING THE YEAR

Because of the tax advantages offered by a flexible benefits plan, IRS rules limit changes during the year to changes in status, such as:

- Marriage or divorce
- Birth, adoption or legal guardianship
- Dependent child no longer meeting the eligibility requirements
- Death of a family member

- A change in your spouse's employment status that affects benefits coverage
- A change in your employment that results in the gain or loss of eligibility for benefits
- Entitlement to, or loss of Medicare or Medicaid coverage
- Significant changes to the cost of the benefit, such as going from full time to a benefited part-time status
- To comply with family relations judgments, decrees or orders such as a qualified medical child support order

Changes must be made within 30 days of the qualifying event and changes must be consistent with the event.

IMPORTANCE OF SIGNING UP
If you do not sign up for employee benefits when first eligible, you will be defaulted to no coverage. As a current benefited employee, if you do not enroll during open enrollment each year, you will remain in your current benefit plan.

BENEFIT OPTIONS OVERVIEW

This chart provides a summary of the benefit choices and coverage options available. These benefits are explained in more detail on the pages that follow.

Benefit Options	**Coverage Options— Per Diem**
Medical No Coverage * Basic Medical and Rx B	Basic Medical and Rx B for employee only or employee + child(ren)

*** Default options for new employees**

MEDICAL PLANS

Having adequate health care coverage is essential to your and your family's health and well-being. Our medical options provide broad, comprehensive protection and cover a wide range of medical services and supplies.

YOUR CHOICES

The medical plan options available to you include:

- Basic Medical

If you elect medical coverage you may choose coverage for:

- Employee only
- Employee plus Child(ren)

Carefully review the following descriptions of the different medical plan options available, as well as the comparison charts on the following pages, before making a decision.

YOUR SHARE OF EXPENSES

As you learn about the specific expenses covered by each plan option, it will help to review some important features.

Deductible – the portion of your medical expenses that you pay each year before the plan pays benefits.

Co-payment – the portion of the fee you pay each time certain services are obtained. This fee is called the co-payment.

Co-insurance – the portion of the fee that you will have to pay each time services are performed after you have met your deductible. You will pay your co-insurance portion until you reach your out-of-pocket limit. The first number by "co-insurance" on the chart is the amount the Plan pays; the second number is the co-insurance you will pay. For example 85/15 means that the Plan pays 85% and you pay 15%.

Out-of-pocket Limit – the maximum amount of co-insurance you will have to pay for eligible medical expenses each year. Once you reach this limit, the plan will pay 100% of covered services for the rest of the plan year. In addition to the maximum co-insurance, you are also responsible for all co-pays and any out of network charges that are considered over usual and customary charges.

Plan Exclusions – Sometimes employees and dependents are surprised when a claim is not approved and paid. Don't be caught unaware. Review the plan exclusions, in the 2018 SMHCS Health and Wellness Plan Exclusion Document available on the HR intranet site of Pulse (Departments>>Human Resources>>Benefits-Medical/Dental/Vision).

BASIC PLAN

The Basic Plan has the lowest premiums and is meant to provide protection for catastrophic medical needs. This plan only covers services provided through the SMHCS and Gulf Coast Select Provider Network. Any care you need will be coordinated by your Primary Care Physician who will also provide referrals and authorizations to SMHCS. All visits to a Specialist require a referral from your Primary Care Physician.

The Basic Plan covers 80% of the cost of the majority of services after a deductible has been met. Physician office visits require a $25 co-payment for each Primary Care Physician visit and a $50 co-payment for Specialist visits. Remember, if you elect the Basic Medical Plan, you must select a Primary Care Physician from the Gulf Coast Select Provider Network when you make your election.

Special Allowance for Out-of-Area Children

Children who live outside of the Gulf Coast Provider Select network area have access to services provided through the nationwide First Health provider network. You are responsible for 20% of the cost after a $1,000 deductible, for out-of-area services for children.

MEDICAL PLAN COMPARISON CHART

Medical Plan Summary	Basic Plan
Deductible (Single/Family Max): **SMHCS** In-Network Out-of-Network Out-of-Area Child Add'l Deductible	 $250/$1,500 N/A $1,000
Facility Co-Insurance: SMHCS In-Network Out-of-Network Out-of-Area Child Co-insurance	 80/20 no deductible N/A N/A 80/20 after deductible
Physician Office Visit Co-payment Out-of-Network Out-of-Area Child	PCP - Initial plan yr visit free, then $25 Specialist $50 N/A 80/20 after deductible
Out-of-Pocket Maximums: (co-insurance limits) In-Network (ind/fam) Out-of-Network	Excludes Deductibles and Co-Pays $2,500/$7,500 N/A
Out-of-Pocket Maximums: (Essential Health Benefits-Med & Rx combined) In-Network (ind/fam) Out-of-Network	Includes Deductibles and Co-Pays $6,600/$13,200 N/A
Emergency Room: SMHCS – Anywhere	 $200 Co-payment Co-pay waived if admitted
Hospital Charges – Inpatient Charges & Outpatient Surgery: SMHCS In-Network Out-of-Network	 80/20 N/A
Wellness: Well Child Care Well Adult Care	Preventive Services covered at 100% Other services covered at 80/20 (subject to deductible) Preventive Services covered at 100% Other services covered at 80/20 (subject to deductible)
Mental – Outpatient: Pine Tree Counseling Center at EAP Located at: 1515 S. Osprey Avenue, Suite C-12 Sarasota, Florida	EAP – Up to 6 counseling sessions per year 100%, Co-pay waived at Pine Tree Counseling Center at EAP Sarasota $25 Co-pay in GCPNS $50 Co-pay for psychiatrist in GCPNS only No annual limit on number of visits

WELLNESS BENEFIT

Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Medical Benefits. Certain additional preventive care services will be covered without your having to pay a co-payment or co-insurance or meet your deductible, so long as the services are provided by a network provider, and are provided in accordance with guidelines from Gulf Coast Medical Management. A current listing of Preventive Care services provided at no cost to you can be accessed at https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1

CHRONIC DISEASE CASE MANAGEMENT

Chronic Disease Case Management is a free program offered to Participants with chronic diseases. Case managers can help a Participant get the care needed and can teach about the disease, help make a treatment plan, arrange doctor visits and help with referrals, and assist with getting treatments. With active participation in the Chronic Disease Case Management program, you may be eligible for a reduction in your Specialist office visit co-pay. For more information visit www.gulfcoastmemberservices.org or call 917-2956.

PRE-AUTHORIZATIONS

All of the medical plans require pre-authorizations for the following procedures:

- Non-emergency hospital admission
- Non-emergency inpatient or outpatient surgery
- Invasive outpatient procedures, including routine endoscopies and colonoscopies
- EGD's, ERCP, Cardiac Cath and office procedures and diagnostics over $1,000 except for Dermatology procedures.
- PET scans
- Hospital admissions due to emergencies within 48 hours (72 hours on weekends and holidays) or as soon as reasonably possible
- Mental Health services must be authorized by EAP

The **Basic Plan** requires a referral from your Primary Care Physician for all visits to a Specialist.

IDENTIFICATION CARDS

If you are enrolling in a medical plan, you will receive an Identification card. You will receive separate identification cards for vision plans you choose.

PRESCRIPTION DRUG COVERAGE

A prescription drug benefit must be selected with your medical plan. Three prescription drug plans are available with each medical option, and these are described in the following Prescription Drug Comparison Chart. If you have elected a Medical Plan, you must choose a Prescription Drug Plan. A Prescription Drug Plan is not available without the Medical Plan.

The Prescription Drug Plans are administered by Navitus Health Solutions. Here's how it works.

- **Retail Pharmacies** (*For short-term prescriptions of 30 days or less):*
  You may have your prescription filled at any of the retail pharmacies that participate in the Navitus network. You will pay the appropriate co-payment for up to a 30-day or 90-day supply of the drug.

- **Mail Order Program** *(For longer-term prescriptions):*
  This feature enables you to receive up to a 90-day supply at a reduced cost compared to retail.

GENERIC VS BRAND DRUGS

Prescriptions typically must be filled with a generic drug when a generic is available. Generic step therapy requires that a cost effective generic alternative is tried first before targeted single source brand medications. Mandatory generic rules steer members to the generic equivalent of the multi-source brand. See more details at www.gulfcoastmemberservices.org under Pharmacy Case Management.

DRUG FORMULARY

All the medical plan options available include a drug formulary, which limits the drugs that are available under the plan. Many times there are several brands of the same drug that are identical in chemical composition but have different costs. The formulary might only contain one or two brands of that drug that have proven to be the most effective and least costly.

PHARMACY CASE MANAGEMENT

A pharmacy case manager is available to work with you to understand your prescription benefit and work with you and your physician to reduce your drug cost by recommending alternative generics. If applicable, RX E plan members will also be referred to a chronic disease case manager. By working with the pharmacy case manager, you will receive an additional $1,000 to your pharmacy cap. You may also want to take this benefit into consideration while calculating your plan choice for the upcoming plan year. The pharmacy case manager can be reached through www.gulfcoastmemberservices.org or at (941) 917-1473.

PRESCRIPTION DRUG PLAN COMPARISON CHART

Prescription Plan	RX B
Prescription Drug Limitations Base Benefit (Net Cost to Employer) Coverage Gap Per Participant (After Base Benefit has been reached) Umbrella Coverage (Begins after coverage gap has been met)	 $2,000 $1,000 50/50
Retail 30 day supply Tier 1 (preferred generics) Tier 2 (preferred brand) Tier 3 (non-preferred brand) Maximum Co-pay Specialty Drugs *Specialty Drugs may require participation in a specialty drug program*	 $9 60/40 - $25 minimum 40/60 $35 minimum $75 per script maximum $100
Compound Drugs *Compounds with a cost greater than $400 require a Compounded Drugs Prior Authorization*	Single source compounds: Non-brand 40% of the cost, not to exceed $60 Brand copay $100; $400 limit per 30 day supply
Retail 90 day Tier 1 (preferred generics) Tier 2 (preferred brand) Tier 3 (non-preferred brand) Maximum Co-Pay Specialty Drugs	 $20 60/40 - $50 minimum 40/60 $75 minimum $75 per script maximum Not Available
Mail Order—90 day supply Tier 1 (preferred generic) Tier 2 (preferred brand) Tier 3 (non-preferred brand) Maximum Co-Pay Specialty Drugs	 $20 60/40 - $50 minimum 40/60 $75 minimum $75 per script maximum Not Available

HOW THE MAIL ORDER PROGRAM WORKS

It is important to plan ahead when you know that you will be using the mail order program. Your first mail order prescription may take up to 21 days for processing due to mailing time and setting up your patient profile in the NoviXus system. Here are some helpful hints for using the prescription drug program.

STEP 1: Talk with your doctor about how the prescription needs to be written.

When you and your physician decide that you need a maintenance drug, request a prescription for a 30-day supply with one refill so that you will be able to fill your prescription at a retail pharmacy while your mail order prescription is being processed. Also request a second written prescription for up to a 90-day supply for the appropriate number of refills to submit through mail order. Talk with your doctor about whether the drug being prescribed is a generic or brand name drug and verify whether it is on Navitus' formulary. This way you will know what your co-payment will be when you mail in your order.

STEP 2: Check your prescription.

Before leaving your physician's office, verify the following items about your prescriptions:

- Is the patient's name legible and spelled correctly on the prescription?
- Is the doctor's name and signature legible?
- Is the doctor's phone number and address on the prescription?
- Is the exact daily dosage indicated?
- Is the exact quantity with the number of refills indicated?
- Is the name and dosage of the drug legible?

STEP 3: Fill out an order form, attach the prescription and enclose the appropriate co-payment.

MAIL ORDER PRESCRIPTION REFILLS

You can order refills by phone, Internet or mail. You should order three weeks in advance of your current prescription running out. Suggested refill dates will be included on the prescription label you receive.

Call (888) 240-2211 or visit www.NoviXus.com to order your refill or to inquire about the status of your order. When you call or log-on to the web site, you will need to provide:

- Your or your dependent's social security number
- Your or your dependent's date of birth
- Your VISA, Discover or MasterCard number with expiration date

To refill by mail, attach the refill label provided with your prescription order to an order form along with a check, money order or credit card information, and mail it in the pre-addressed envelope included with your previous shipment.

EMPLOYEE ASSISTANCE PROGRAM

SMHCS understands that employees today must often deal with stressful situations. When these issues become too difficult to manage, you are encouraged to use the Employee Assistance Program (EAP).

EAP SERVICES

EAP Sarasota (EAP) provides professional counseling, referral, and follow-up services for you and members in your household. You and your family members are eligible for up to six free counseling sessions per year. In addition, EAP has expanded its services and is offering continued long-term counseling through the medical benefits plans. EAP also provides drug management services for adult participants who are taking medications for behavioral health conditions.

EAP can provide you with confidential information regarding personal problems or information regarding special services including:

- Marital and Family Related Issues
- Parent-Child/Adolescent Problems
- Relationship Issues
- Depression and Anxiety
- Grief and Loss
- Work or School Problems
- Substance Abuse
- Financial and Legal Difficulties
- Child Care Facilities
- Emergency Mental Health Care
- Wellness Coaching
- Smoking Cessation

MAKING AN APPOINTMENT

You will be allowed time off during work hours to talk with a counselor. Or, if you do not wish to ask your supervisor for time off, an appointment can be made for some other time.

WHO TO CONTACT

An appointment can be made by calling (941) 917-1240 or (800) 425-7764.

VOLUNTARY BENEFITS

SMHCS provides you with opportunities to purchase additional voluntary benefits and pay for them through payroll deduction.

HEALTHFIT WELLNESS AND FITNESS PROGRAM

HealthFit offers discounts to employees, including the employee gym on the 4th floor of the main hospital. For details please call (941) 917-7000.

AFLAC INSURANCE

Several different plans are available through AFLAC. Offerings include several plans that provide supplemental benefits for accidents and illnesses. Contact the AFLAC representative at (941) 756-6192 for more information.

SMHCS CHILD CARE SERVICES

SMHCS has two child care centers. Both centers are licensed and participating in the Look for the Stars Quality Improvement System of Sarasota County. For information regarding the Child Care Centers please call (941) 917-1477 or (941) 917-2535.

WHERE TO GET HELP

RESOURCE	PHONE NUMBER
Human Resources Service Line	(941) 917-6177
AFLAC	(941) 756-6192
Employee Assistance Program (EAP)	(941) 917-1240 or (800) 425-7764
Employee Discounts (HeroCare)	1-877-437-6411
Employee Health	(941) 917-7320
Gulf Coast Medical Management	(941) 917-8004 or (866) 260-0305
Gulf Coast Provider Network	(941) 917-8004 or (866) 260-0305
HealthFit	(941) 917-7000
Medical Plans (WebTPA)	(877) 697-2299 or (941) 917-7991
Navitus Health Solutions	(866) 333-2757
NoviXus (Mail Order Rx)	(888) 240-2211
SMHCS Chronic Disease Case Manager	(941) 917-2956
SMHCS Pharmacy Case Manager	(941) 917-1473
SMHCS Child Care Center	(941) 917-1477 or (941) 917-2535
Transamerica (Medicare Supplemental Plans)	(941) 928-7551

HUMAN RESOURCES DEPARTMENT

Human Resources is open Monday through Friday from 7:30 a.m. to 4:00 p.m. The HR Service Line is (941) 917-6177. The HR website on the SMHCS intranet contains information and forms for all Human Resources topics. Below is an example of the information that is available there.

- Health Plan and Spending Account Claim Forms
- Personal Data Change Form
- Deduction/Banking Change Form
- Employee Handbook
- Prescription Forms
- Health Plan Summary Plan Description
- Leave of Absence Forms
- Links to benefits providers
- Insurance Status Change Forms
- Retirement Savings Plans Enrollment and Change Forms

WEBTPA MEDICAL PLAN PARTICIPANT SERVICES

Participants in the medical plan may access their medical claims status and history, explanation of benefits, and eligibility information at any time through WebTPA's online service. To access the services, go to www.webtpaes.com and login as a member. Click "First time to log on" and enter the requested information. WebTPA will mail you a letter with your password. You may also request new insurance cards through this website.

USEFUL WEBSITES

WebTPA (Eligibility status, claim history) - www.webtpaes.com

Chronic Disease Case Management - www.gulfcoastmemberservices.org

Gulf Coast Medical Management - www.gulfcoastmemberservices.org

Gulf Coast Provider Network – www.gulfcoastprovider.net

HeroCare (Employee discounts) – www.HeroCare.org

Navitus Health Solutions – www.navitus.com

NoviXus – www.novixus.com

Pharmacy Case Management – www.gulfcoastmemberservices.org

Preventive Services - https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1

ADDRESSES

Medical Claims Administrator	WebTPA Employer Services P. O. Box 99906 Grand Prairie, TX 76099
Mail Order Prescriptions	www.NoviXus.com P.O Box 8004 Novi, Michigan 48376-8004