2018 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.

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

Rather than providing a fixed level of benefits for all employees, the SMHCS benefits program offers a number of different options. You could think of this as a "menu" of benefits from which you can choose. With our Benefits program, you can design a benefit plan that's right for you.

CHOOSE COVERAGE UNDER THESE PLANS

The Benefit program offers choices in these areas:

- Medical
- Dental
- Vision
- Short-term disability
- Long-term disability
- Employee life and accidental death and dismemberment (AD&D) insurance
- Dependent life insurance
- Flexible spending accounts (health care and dependent care)

WHO CAN ENROLL

All full-time regular employees of SMHCS that are statused to work 35 hours or more per week, and all part-time regular employees statused to work 20 hours or more per week are eligible to enroll in the benefits program. Also, 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 Plans and the Premium and Standard Dental Plans include your spouse and any 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 spouse:
  - Marriage Certificate and two additional documents proving joint ownership. Acceptable documents proving joint ownership are: mortgage statements, credit card statements, bank statements, and leasing agreements listing both parties' names as co-owners. The joint ownership may be established prior to the current year; however the statement provided must be issued within the last three months.

- 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. However, if you elect dependent life insurance or short-term disability, you pay for it with after-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 new employees on the 61st day of employment. We encourage you to enroll on-line within your first 30 days of employment so that you have your ID cards by your effective date.

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 as a full-time new hire, you will be defaulted to the Basic Life insurance and the 50% Long-Term Disability plans only; you will not be enrolled in any other benefit. As a part-time new hire, you will not be defaulted to any benefit plan. As a per diem employee, you will not be defaulted to any benefit plan.
As a current benefited employee, if you do not enroll you will remain in your current benefit plans.

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—Full Time	Coverage Options—Part Time	Coverage Options—Per Diem
Medical No Coverage * Comprehensive Medical and Rx B Comprehensive Medical and Rx C Comprehensive Medical and Rx E Basic Medical and Rx B Basic Medical and Rx C Basic Medical and Rx E Extended Medical and Rx B Extended Medical and Rx C Extended Medical and Rx E	Employee Only Employee plus Spouse Employee plus Child(ren) Employee plus Family	Employee Only Employee plus Spouse Employee plus Child(ren) Employee plus Family	Basic Medical and Rx B for employee only or employee + child(ren)
Dental No Coverage * Aetna Premium Plan Aetna Standard Plan Humana Plan	Employee Only Employee plus Family	Employee Only Employee plus Family	Not Available
Vision No Coverage * Humana VisionCare	Employee Only Employee plus Family	Employee Only Employee plus Family	Not Available
Short-term Disability (STD) No Coverage * 60 % Option	Employee Only	Not Available	Not Available
Long-term Disability (LTD) No Coverage 50 % of eligible earnings * 66 2/3 % of eligible earnings	Employee Only	Not Available	Not Available
Life and AD&D Insurance $10,000 Basic Life *	Employee Only	Employee Only **	Not Available
Supplemental Life No Coverage * 1 x pay, 2 x pay, 3 x pay, or 4 x pay	Employee Only	Not Available	Not Available
Dependent Life Insurance No Coverage * Dependent Life – Spouse $5,000 Dependent Life – Spouse $10,000 Dependent Life – Spouse $25,000 Dependent Life – Child(ren) $2,500 Dependent Life – Child(ren) $5,000 Dependent Life – Child(ren) $10,000	Spouse Spouse Spouse Children Children Children	Spouse Not Available Not Available Children Children Not Available	Not Available
Flexible Spending Accounts No Contribution * Health Care Account Dependent Care Account	Up to $2,550 per year Up to $5,000 per year (or up to $2,500 if you are married and file taxes separately or single)	Up to $2,550 per year Up to $5,000 per year (or up to $2,500 if you are married and file taxes separately or single)	Not Available

*** Default options for new employees ** Part time and Per Diem employees defaulted to no coverage**

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:

- Comprehensive Medical
- Basic Medical
- Extended Medical

If you elect medical coverage you may choose coverage for:

- Employee only
- Employee plus Spouse
- Employee plus Child(ren)
- Employee plus Family

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. You may choose one of three levels of prescription benefits that are available for each medical plan; a detailed comparison chart of prescription benefits is on page 12.

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).

COMPREHENSIVE PLAN

The Comprehensive Plan has the lowest out-of-pocket cost and no deductible. This plan only covers services provided through the SMHCS and Gulf Coast Select Provider Network. The Gulf Coast Select Provider Network includes a large number of local providers and you must select a Primary Care Physician from this network when making your election.

The Comprehensive Plan covers 85% of the cost of services rendered by a network provider. Physician office visits require a $25 co-payment for each Primary Care Physician visit and a $50 co-payment for Specialist visits. You are required to get a referral from your Primary Care Physician after two visits to the same type of specialist.

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.

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.

EXTENDED PLAN

The Extended Plan has the highest premiums and out-of-pocket costs. In-network benefits are provided through the SMHCS and Gulf Coast Provider Network, which includes a large number of local providers. You may visit any Specialist or facility without a referral or authorization.

The Extended Plan covers 85% of the cost of services rendered by an SMHCS provider and 60% of the cost of an in-network provider after the deductible has been met. There is no deductible for services rendered at an SMHCS facility, but deductibles do apply to in-network and out-of-network services. Physician office visits require a $25 co-payment for each Primary Care Physician visit and a $50 co-payment for Specialist's in-network. Physician office visits for out-of-network require a deductible then a $25 co-payment for your Primary Care Physician. For each out-of-network Specialist visit, first you meet your deductible then a $50 co-payment.

For a comparison of the key features of the medical options, refer to the Medical Plan Comparison Chart on the next pages.

MEDICAL PLAN COMPARISON CHART

Medical Plan	Comprehensive Plan	Basic Plan	Extended Plan
Deductible (Single/Family Max):			
SMHCS	$0.00	$250/$1,500	$0.00
In-Network	$0.00	$250/$1,500	$1,500/$4,500
Out-of-Network	N/A	N/A	$2,500/$8,500
Out-of-Network Add'l Hospital Deductible	N/A	N/A	$1,000
Out-of-Area Child Add'l Deductible	$1,000	$1,000	N/A
Facility Co-Insurance:			
SMHCS	85/15 no deductible	80/20 no deductible	85/15 no deductible
In-Network	N/A	N/A	60/40 after deductible
Out-of-Network	N/A	N/A	40/60 after deductible
Out-of-Area Child Co-insurance	80/20 after deductible	80/20 after deductible	60/40 after deductible if in-network
Physician Office Visit	PCP - Initial plan yr visit free, then $25	PCP - Initial plan yr visit free, then $25	PCP - Initial plan yr visit free, then $25
Co-payment	Specialist $50	Specialist $50	Specialist $50
Out-of-Network	N/A	N/A	PCP-deductible then $25 Specialist-deductible then $50
Out-of-Area Child	80/20 after deductible	80/20 after deductible	PCP-deductible then $25 Specialist-deductible then $50
Out-of-Pocket Maximums: (co-insurance limits)	Excludes Deductibles and Co-Pays	Excludes Deductibles and Co-Pays	Includes Deductibles and Co-Pays
In-Network (ind/fam)	$1,500/$4,500	$2,500/$7,500	$6,350/$12,700
Out-of-Network	N/A	N/A	Unlimited

Medical Plan	Comprehensive Plan	Basic Plan	Extended Plan
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	Includes Deductibles and Co-Pays $6,600/$13,200 N/A	Includes Deductibles and Co-Pays $6,600/$13,200 Unlimited
Emergency Room: SMHCS – Anywhere Non-Emergency	$200 Co-payment Co-pay waived if admitted N/A	$200 Co-payment Co-pay waived if admitted N/A	$200 Co-payment Co-pay waived if admitted N/A
Hospital Charges – Inpatient Charges & Outpatient Surgery: SMHCS In-Network Out-of-Network	 85/15 N/A N/A	 80/20 N/A N/A	 85/15 60/40 after deductible 40/60 after deductible
Wellness: Well Child Care Well Adult Care	Preventive Services covered at 100%; other services covered at 85/15 Preventive Services covered at 100%; other services covered at 85/15	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)	Preventive Services covered at 100%; other services covered with co-pay Preventive Services covered at 100%; other services covered with co-pay Preventive Services and Wellness Visits not covered out-of-network
Mental – Outpatient Pine Tree Counseling Center at EAP Located at: 1515 S. Osprey Avenue, Suite C-12 Sarasota, Florida Corner of Floyd Street and Osprey Avenue	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	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	EAP – Up to 6 counseling sessions per year 100%, Co-pay waived at Pine Tree Counseling Center at EAP Sarasota 50/50 (In-network, non-SMHCS providers) (Subject to deductible) 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 **Comprehensive Plan** requires a referral from your Primary Care Physician after two visits to the same type of specialist.

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.

Aetna does not automatically provide dental cards. You can contact Aetna at www.aetna.com and request dental cards.

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.

For a comparison of the key features of the prescription drug options, refer to the Prescription Drug Plan Comparison Chart on the next pages.

PRESCRIPTION DRUG PLAN COMPARISON CHART

Prescription Plan	RX C	RX B	RX E
Prescription Drug Limitations Base Benefit (Net Cost to Employer)	$3,000	$2,000	$7,000
Coverage Gap Per Participant (After Base Benefit has been reached)	$1,000	$1,000	$1,000
Umbrella Coverage (Begins after coverage gap has been met)	50/50	50/50	50/50 without Case Mgmt 60/40 with Pharmacy Case Mgmt 80/20 with Pharmacy & Chronic Disease Case Mgmt
Retail 30 day supply Tier 1 (preferred generics)	$9	$9	$9
Tier 2 (preferred brand)	60/40 - $25 minimum	60/40 - $25 minimum	60/40 - $25 minimum
Tier 3 (non-preferred brand)	40/60	40/60	40/60
Maximum Co-pay	$35 minimum $75 per script maximum	$35 minimum $75 per script maximum	$35 minimum $100 per script maximum
Specialty Drugs *Specialty Drugs may require participation in a specialty drug program*	$100	$100	$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	Single source compounds: Non-brand 40% of the cost, not to exceed $60 Brand copay $100; $400 limit per 30 day supply	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)	$20	$20	$20
Tier 2 (preferred brand)	60/40 - $50 minimum	60/40 - $50 minimum	60/40 - $50 minimum
Tier 3 (non-preferred brand)	40/60	40/60	40/60
Maximum Co-Pay	$75 minimum $75 per script maximum	$75 minimum $75 per script maximum	$75 minimum $100 per script maximum
Specialty Drugs	Not Available	Not Available	Not Available

Prescription Plan	RX C	RX B	RX E
Mail Order—90 day supply			
Tier 1 (preferred generic)	$20	$20	$20
Tier 2 (preferred brand)	60/40 - $50 minimum	60/40 - $50 minimum	60/40 - $50 minimum
Tier 3 (non-preferred brand)	40/60 $75 minimum	40/60 $75 minimum	40/60 $75 minimum
Maximum Co-Pay	$75 per script maximum	$75 per script Maximum	$100 per script maximum
Specialty Drugs	Not Available	Not Available	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.

DENTAL PLANS

Regular, professional dental care is not only important to good health, but can also prevent serious and costly problems later on.

YOUR CHOICES

You have the choice of three dental plans, which are described below.

If you elect coverage under the dental plan, you can enroll:

- Employee only
- Employee and family

The plan pays a percentage of the Usual and Customary rates (UCR)

DENTAL PLAN COMPARISON CHART

Dental Plan Summary	Premium Plan (Aetna)	Standard Plan (Aetna)	Humana
Deductible	None	None	None
Preventive	Plan pays 90% of UCR	Plan pays 80% of UCR	Free or paid on a set fee schedule (see dental fee schedule)
Basic	Plan pays 90% of UCR	Plan pays 80% of UCR	Free or paid on a set fee schedule (see dental fee schedule)
Major	Plan pays 60% of UCR	$50 deductible Plan pays 50% of UCR	See Humana fee schedule
Orthodontics	Plan pays 50% UCR $500 max per quarter $1,000 lifetime	None	Humana has Orthodontic benefits (see dental fee schedule)
Annual Maximums	$2,000	$1,000	None

Preventative Services Include	Basic Services Include	Major Services Include
Oral Exams Teeth Cleaning X-Ray	Emergency Exams Consultations Oral Surgery Anesthesia Extractions Impacted Teeth Root Canals Periodontics Fillings Pin Retention	Inlays Onlays Crowns Bridges Dental Implants* Dentures Reline Denture Adjustments Partials * Included in Premium Plan only

DENTAL NETWORK

If you elect the Premium or Standard plan, you may go to any dentist you wish. However, if you select a dentist from the Aetna PPO Network, you will not be balance billed for charges above the network fee. A list of providers in Aetna's PPO network is available at www.aetna.com . If you choose the Humana Dental plan, you must choose a provider within the Humana Network, available at www.compbenefits.com/custom/sarasota_mh/ .

VISION PLAN

The Humana Vision Plan provides benefits for routine eye exams, lenses and frames, and contact lenses.

YOUR CHOICES

If you elect coverage under the vision plan, you can enroll:

- Employee only
- Employee and family

HOW THE VISION PLAN WORKS

- Select a doctor from the list available at www.humana.com and make an appointment.
- Present your Humana Vision ID card when you visit the doctor. You pay any co-payments at this time.
- The doctor provides you with a complete eye exam, and when necessary, orders prescribed eyeglasses for you from a VisionCare approved lab. The doctor also verifies the accuracy of your glasses and fits them on you.
- When you select a doctor from the VisionCare network, your co-pay is $10 for the exam and $15 for any prescribed materials, as long as you stay within the plan's allowances.

VISION PLAN HIGHLIGHTS	
Vision examination	Every 12 months
Lenses	Every 12 months (if needed)
Frames	Every 24 months (if needed)
Contacts	Covered if medically necessary – prior authorization from VisionCare
Elective contacts	Flat allowance of $125 including lenses and follow-up visits

DISABILITY PLANS

Our Benefits include a short-term disability plan and a long-term disability plan that are designed to work together to provide important financial protection if you are unable to work due to illness or injury. SMHCS's long-term disability plan combines with Social Security and other benefits you may receive to provide you with a percentage of your pre-disability income. The following charts provide highlights of each plan as well as the benefit options associated with each.

SHORT-TERM DISABILITY (STD)

Eligible Employees *	You are eligible to enroll in the STD plan if you are statused to work 35 hours or more per week.
Waiting Period Before Benefits Would Begin	Benefits begin after: • 7 consecutive calendar days of illness (including 5 days or 40 hours of missed scheduled work), and your accumulated Bank B hours have been used
Benefit Option	• 60% of your basic weekly earnings, to a maximum of $2,500 per week.
Benefit Period	• Short-term disability may extend through a maximum of 25 weeks, less any Bank B time.

STD is an after-tax benefit, so you do not pay income taxes on the benefit you receive.
* FPG Physicians are not eligible for short-term disability.

LONG-TERM DISABILITY (LTD)

Eligible Employees	You are eligible to enroll in the LTD plan if you are statused to work 35 hours or more per week.
Waiting Period before Benefits Would Begin	Benefits begin after: • you have been disabled for 180 days ***For FPG physicians only***, benefits begin after you have been disabled for 90 days.
Benefit Option	You may choose from two options: • 50% of pay, or • 66 2/3% of pay The maximum monthly benefit is $8,000. ***For FPG physicians only***, plan provides 60% pay replacement up to a maximum benefit of $10,000.
Benefit Period	Long-term disability benefits may begin on the 181st day of disability and may continue as long as your disability continues (with certain restrictions based on when you became disabled).

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Although most of us never think about life and AD&D insurance, it's important to have protection against unexpected tragedies. This section explains the survivor benefits that SMHCS offers.

EMPLOYEE LIFE & AD&D INSURANCE AND SUPPLEMENTAL LIFE AND AD&D

Life insurance provides benefits in the case of your death; accidental death and dismemberment (AD&D) provides benefits in the case of death or severe injury due to an accident. AD&D benefits depend on the extent of the injury.

SMHCS provides $10,000 basic life and AD&D coverage to full-time employees at no charge. Part-time employees are eligible to purchase basic life and AD&D coverage.

Full-time employees are also eligible to purchase supplemental life insurance in the following options:

- 1 x base annual earnings
- 2 x base annual earnings
- 3 x base annual earnings
- 4 x base annual earnings

DEPENDENT LIFE INSURANCE

You may elect life insurance for your spouse and children, if you wish. The following dependent life insurance options are available.

- No coverage
- Spouse Life
  - o $5,000 o $10,000 o $25,000
- Child(ren) Life
  - o $2,500 o $ 5,000 o $10,000

You must elect at least twice as much life insurance for yourself as you elect for your spouse or your children.

You may elect coverage for your children without electing coverage for your spouse and vice versa. If you elect coverage only for your children you must elect at least twice as much life insurance for yourself.

Your unmarried dependent children are covered from age 6 months to age 19 years, or to age 26 if a full-time student. From birth to age 6 months, 10% of the amount above is payable.

If both parents are employees, only one will be eligible for dependent coverage with respect to their dependent children.

FLEXIBLE SPENDING ACCOUNTS

The Flexible Spending Accounts allow you to use tax-free dollars to pay for eligible health care and dependent care expenses that aren't covered elsewhere. As the example shows, depositing money in the Flexible Spending Accounts lowers your taxable income—and you pay fewer taxes.

HOW THE ACCOUNTS WORK

You elect how much to contribute on a before-tax basis to each account. Your contributions are deducted from your pay throughout the year and deposited to your accounts. You reimburse yourself for eligible expenses incurred during the calendar year by filing claims. Simply submit a claim form along with proper documentation for those expenses to Human Resources.

Please note** This is a reimbursement program. There is no debit card for direct deduction associated with these Flexible Spending Account programs.

While the rest of the Benefit plans are effective from October through September, your flexible spending accounts will be effective from January through December. A separate open enrollment period is held in the fall for enrollment in the flexible spending accounts.

EXAMPLES OF TAX SAVINGS

The tax advantages of flexible spending accounts can really add up.
Here's an example:

Combined Family Income	$42,000
Deposits to spending accounts	$ 3,000
Tax savings *	$ 900

** Assumes a 30% tax rate (for federal and FICA taxes).*

This family would save $900 a year by using the spending accounts for qualifying expenses.

HEALTH CARE ACCOUNT

ELIGIBLE EXPENSES

Use this account to reimburse for eligible expenses that aren't covered by the medical, dental or vision plans, such as:

- deductibles and co-payments
- co-insurance amounts
- charges above the usual and customary amount covered by an employer-sponsored plan
- eye exams
- the purchase of eyeglasses, contact lenses and solutions
- hearing aids
- chiropractic care (with RX from PCP)
- cosmetic surgery, but only if the surgery is necessary to improve a deformity resulting from a congenital abnormality, disease or injury

- purchase of rental prosthetic devices or the cost of surgical implants
- acupuncture treatments for pain control but not for behavior modifications (with RX from PCP)
- purchase or rental of wheelchairs
- prescribed drugs, whether or not considered experimental by the FDA (both the payment receipt and pharmacy RX stub are required for reimbursement of all prescriptions)
- prescription birth control drugs or devices
- ambulance services
- oxygen and related equipment
- blood and blood plasma
- physical therapy or hydrotherapy (with RX from PCP)
- fees for lab tests and x-rays
- purchase of a guide dog for a blind or deaf individual
- orthopedic appliances prescribed by a doctor for personal use but not for business use
- physical exams, well-baby care, and immunizations

EXPENSES THAT DON'T QUALIFY

The following are examples that cannot be reimbursed through the health care spending account:

- over-the-counter drugs used to treat an illness or condition, unless prescribed by a physician
- amounts paid or eligible to be paid by any health care plan
- cosmetic surgery expenses, including teeth whitening
- medical expenses for which you take an itemized tax deduction on your federal income tax return (expenses must be more than 7.5% of your annual adjusted gross income)
- non-prescription drugs
- expenses for recreation health clubs and nutrition for general health and well-being, even if prescribed by a doctor
- premiums paid for medical coverage
- vitamins or supplements, unless prescribed by a doctor to treat a specific illness.

ANNUAL DEPOSITS

Beginning January 1, 2017 you can deposit up to $2,600 annually on a before-tax basis into this account.

To figure the amount that you want deducted from each paycheck, divide the annual amount by 26. **You must enroll each year in order to continue in the plan**.

DEPENDENT CARE ACCOUNT

Use the dependent care account to reimburse for eligible expenses for the care of your children or possibly a disabled adult. Eligible dependents include:

- your children under age 13 whom you claim as dependents for income tax purposes
- adult dependents who spend at least eight hours in your home each day and who are unable to care for themselves because of a mental or physical disability

ELIGIBLE EXPENSES

Expenses for the following types of services can be reimbursed through this account:

- child care services in your home or someone else's
- service in a dependent care center that complies with all state and local regulations
- services of a housekeeper whose duties include, in part, providing for a qualified dependent
- adult dependent care in your home or someone else's
- summer day camp

EXPENSES THAT DON'T QUALIFY

Certain expenses are not eligible for reimbursement, such as:

- child care or baby-sitting services by your spouse, or by someone you can claim as an exemption on your federal income tax return, or by one of your children who is under age 19
- housekeeping expenses not related to dependent care
- food or clothing expenses for a dependent
- transportation expenses between your home and the location where dependent care is provided
- dependent care expenses that you claim on your federal tax return
- dependent care expenses from a facility that is not a qualified dependent care center (such as one that does not meet licensing requirements)
- expenses for overnight (boarding) camp

TAX CREDIT VS. SPENDING ACCOUNT

You can claim the child care credit on your federal income tax return or use your spending account for dependent care expenses. You cannot claim the same expenses under both.

Generally, if the total adjusted annual income for your household is $24,000 or more, you may benefit by using the spending account. If your household income is less, your individual situation (such as marital status, income level, number of dependents, etc.) will influence which is the better choice. A tax advisor can help you determine which approach is better for you.

YOUR DEPOSITS

Through payroll deductions, you can deposit $2,500 annually if you are claiming single on your tax return or up to $5,000 annually if you are married and file a joint tax return to reimburse yourself for

the cost of dependent care services.

PLAN CAREFULLY

It's important that you plan carefully so that you get the most out of your spending accounts. Contribute only as much as you think you will need. Some helpful hints:

- **Review your health care claims and your checkbook –** What portion of your health care expenses have you paid out of your own pocket over the last few years?

- **Consider your health status and that of your family –** Are you expecting any costly treatments in the next year?

- **Check with dependent caregivers and summer camps –** Are costs likely to increase next year? Will they provide you with a tax I.D. number or Social Security number? (You must have one of these to get reimbursed).

When deciding how much to deposit in these accounts, keep the following IRS rules in mind:

- **Any money left in your accounts after the end of the year will be lost** since it cannot be returned to you or carried over into the next year. (Claims must be postmarked by March 31st of the year after the year claims were incurred).

- The health care and dependent care accounts must be maintained separately. Money cannot be transferred from one account to the other.

- The Health and Dependent care accounts are reimbursement accounts. They are not used to pay items outright. You must first provide proper documentation showing the out of pocket expense that was paid prior to receiving reimbursement.

- For reimbursement of all claims for Health care accounts, documentation of portions covered or denied by insurance must be provided. Estimates of coverage are not eligible to be used.

Flexible Spending Account claim forms are available on the HR site of Pulse.

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.

SMH HEALTH CARE RETIREMENT SAVINGS PLAN

The 403(b) plan gives you the opportunity to save up to an annual maximum of $18,000 on a tax-deferred basis, based on the IRS 2017 limits. If you are 50 years old or over, there is a special catch-up provision that allows you to defer up to $24,000, based on the IRS 2017 limits.

The real value of these plans is that you not only save money for retirement but you also decrease the amount of federal income tax you have to pay. You have control over how your money is invested and there are many investment options from which you can choose.

HOW TO SIGN-UP

SMHCS offers the 403(b) plan through two vendors, Lincoln and Voya (formerly ING.) You can work with representatives from either of these companies to determine the level of contribution you wish to make. Your contributions will be set up as pre-tax payroll deductions. Employees hired on or after October 1, 2009 are only eligible to participate in the Lincoln Alliance program.

THE EFFECTS OF CONTRIBUTING TO THE 403(b) PLAN

This example is based upon an annual salary of $40,000 and the participant being in the 28% tax bracket.

	Contributes to 403(b)	**Does Not Contribute to 403(b)**
Gross Pay per Pay Period	$1,538.46	$1,538.46
403(b) Contribution	$150.00	$0.00
Federal Income Tax	$388.76	$430.76
Net Income	$999.70	$1,107.70

Although the person who contributed to the 403(b) contributed **$150.00** per pay period, their take-home pay was only reduced by **$108.00** due to the reduction in gross earnings.

PAID TIME OFF

SMHCS provides paid time off for taking time off for rest and relaxation and for extended illnesses.

PTO BANK A

PTO Bank A is provided to regular employees for time off for vacation, holidays, personal days and occasional illness. Bank A hours accrue each pay period based upon your hours worked. The accrual schedule is shown below. Your PTO Bank A may accumulate up to a maximum of 320 hours.

Service	Accrual per Hours worked	Annual Accrual (based on 1.0 FTE)	Per Pay Period Accrual (based on 80 Hour pay period)
0 to less than 2 years*	0.09231 hours	24 days	7.38 hours
2 years but less than 5 years	0.1 hours	26 days	8.00 hours
5 years but less than 10 years	0.11538 hours	30 days	9.23 hours
10 or more years	0.12688 hours	33 days	10.15 hours

** Employees of Sarasota Memorial Nursing and Rehab Center accrue PTO A at the 24 days per year level until 5 years of service. FPG Physicians need to check their specific contracts for vacation details.*

PTO BANK B

PTO Bank B is provided to regular employees for extended illnesses. The purpose of Bank B is to protect your income in case of a short-term disability. Bank B hours accrue each pay period based upon your hours worked. The accrual schedule is shown below. Your PTO Bank B may accumulate up to a maximum of 800 hours. Employees of Sarasota Nursing and Rehab Center are not eligible for PTO B.

Accrual per hour worked	Annual Accrual (based on 1.0 FTE)	Per Pay Period Accrual (based on 80 hour pay period)
0.03075 hours	8 days	2.46 hours

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
Aetna Dental Plans	(877) 238-6200
AFLAC	(941) 756-6192
Dependent Life (Liberty Mutual)	(888) 787-2129
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
Humana Dental	(800) 342-5209
Humana VisionCare	(877) 398-2980
Life & AD&D (Liberty Mutual)	(888)787-2129
Lincoln (403 b)	(800) 234-3500
Long-Term Disability Claim (Liberty Mutual) Disability Claim Intake Line (24/7/365)	(800) 291-0112 (800) 713-7384
Medical Plans (WebTPA)	(877) 697-2299 or (941) 917-7991
Navitus Health Solutions	(866) 333-2757
NoviXus (Mail Order Rx)	(888) 240-2211
Short-Term Disability Claim (Liberty Mutual) Disability Claim Intake Line (24/7/365)	(800) 291-0112 (800) 713-7384
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
Voya (formerly ING) (403 b)	(866) 818-5899

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

Aetna PPO Dental – www.aetna.com; www.aetnanavigator.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

Humana Dental - www.compbenefits.com/custom/sarasota_mh/

Humana Vision – www.humana.com

Liberty Mutual Life and Disability – www.MyLibertyConnection.com

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

SMH Retirement Plan - https://eepoint.towerswatson.com/sites/SMH/ESS/Logon.aspx

ADDRESSES

Medical Claims Administrator	WebTPA Employer Services P. O. Box 99906 Grand Prairie, TX 76099
Aetna Dental Claims	Aetna Inc. P. O. Box 14094 Lexington, KY 40512
Mail Order Prescriptions	www.NoviXus.com P.O Box 8004 Novi, Michigan 48376-8004