

FY2020



Benefit Guide

Sarasota Memorial Health Care System

Retiree Medical and COBRA Participants

smh Care

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Welcome Letter

Sarasota Memorial Health Care System offers an inclusive, flexible compensation and benefits package to help you take care of yourself and your family, even after you've left SMH.

This guide highlights the information you will need to make your choices. We have a few changes to the plan offerings for 2020. We have incorporated a "What's New" page for a quick overview of the changes for your review.

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 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, 2019.

What's New

Category	
Pharmacy Cap Increase	<ul style="list-style-type: none"> Additional Cap increase from \$1,000 to \$1,500 for working with the SMH Pharmacy Case Manager at Gulf Coast Medical Management
Hearing Aids	<ul style="list-style-type: none"> Fiscal 2019 SMH began covering hearing aids for dependents age 18 years old or younger with hearing loss related to medical conditions Now additional discounts on all hearing aids and batteries, through Aetna partnered vendors
Expanded Substance Abuse coverage	<ul style="list-style-type: none"> Substance Abuse coverage added to the Basic Plan
Increased Immunization coverage	<ul style="list-style-type: none"> Coverage for preventive immunizations now covered under both pharmacy and medical plans. This allows plan members to receive inoculations at an SMH urgent care center, a pharmacy, or a doctor's office
Employee Assistance Program (EAP)	<ul style="list-style-type: none"> New external Employee Assistance Program (EAP) partner, Health Advocate Additional services offered, still with 6 free visits per issue with unlimited phone support Around the clock services to help with personal, family, and work issues, such as: <ul style="list-style-type: none"> Grief, loss, depression Relationship issues, divorce Job stress, burnout, work/life balance New baby, adoption, eldercare Addiction, eating disorders, mental illness, and more Online training courses, videos, and help articles for all of the above topics, in addition to in-person or phone counseling available
Digital Wallet Card	<ul style="list-style-type: none"> Important contact numbers in one place Download on your PC or your mobile device by going to www.mymobilewalletcard.com/smh

Benefit Basics

Sarasota Memorial Health Care System (SMHCS) offers a comprehensive suite of benefits to promote health and financial wellness for you and your family.

This booklet provides a summary of your benefits. Please review it carefully so you can choose the coverage that is right for you.

Benefit Basics

As a SMHCS former employee, you and your eligible dependents may enroll in the SMHCS health and welfare benefits program.

Your dependents can also enroll for coverage, including:

- Your legal spouse
- Your children up to age 26

Remember that you may only change coverage if you experience a qualifying life event, as described below.

Qualifying Life Events

During the plan year, you may only make or change your existing benefit elections during the open enrollment window. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- New entitlement to Medicare or Medicaid

You must notify Human Resources within 30 days of a qualifying life event. Depending on the type of event, you may need to provide proof of the event, such as a marriage license. Human Resources will let you know what documentation you should provide. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next open enrollment window to make changes (unless you experience another qualifying life event).

Proof of Relationship is required to enroll all Dependents.

Acceptable Proof of Relationship documents are:

- First page of your most recent Federal Tax Return, Form 1040 (All dependents)
 - Must list full name and social security number of all participants in the SMHCS healthcare plan (please black out all financial data)
- Marriage Certificate and two additional documents proving joint ownership. (Spouse)
- Birth Certificate (Dependent Children under age 26)
- Birth Certificate and copy of current full- or part-time School Schedule (Unmarried dependent children age 26 and older)
- Physician's Certifications for disabled children (Unmarried dependent children age 26 and older)

Health Care Coverage

Your health care coverage includes medical, dental and vision plans. Detailed information about each plan is in this section. If you have questions, please contact Human Resources.

Each medical plan has varying features of in- and out-of-network coverage; individual and family deductibles; copays; coinsurance; and out-of-pocket maximums.

You have three medical plan options:

- **Comprehensive Medical**
- **Basic Medical**
- **Extended Medical**

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 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.

You have three Prescription plan options:

- **Rx C**
- **Rx B**
- **Rx E**

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 \$1,500 to your pharmacy cap. You may also want to take this benefit into consideration while calculating your plan choice for the upcoming plan year.



In/Out-of-Network Coverage

In some of the plans, you may use in- or out-of-network providers. You will always pay less if you see a doctor or receive services within the provider network.

For a definition of these terms, refer to the Glossary on page 17.

Deductible

In some plans, you must meet an annual deductible before the medical plan begins to cover a portion of your costs. Once the deductible is met, the medical plan begins to pay for a percentage of covered expenses (this is called coinsurance).

Out-of-pocket Maximums

Out-of-pocket maximums apply to all of the plans. This is the maximum amount you will pay for health care costs in a fiscal year. Once you have reached the out-of-pocket maximum, the plan will fully cover eligible medical expenses for the rest of the benefits plan year. If you see an out of network provider, you may be responsible for out-of-pocket costs that are considered above the “reasonable and customary” fees.

You decide which medical plan will work best for you and your family based on the monthly cost of coverage, the annual deductible, and the out-of-pocket maximum

Medical Coverage

SMHCS offers a choice of medical plan options through SMHCS and Gulf Coast Provider Network; you choose the plan that meets the needs of you and your family. Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs.

Plan Provisions	Comprehensive Plan	Basic Plan	Extended Plan		
	SMHCS	SMHCS	SMHCS	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	\$0/\$0	\$250/\$1,500	\$0/\$0	\$1,500/\$4,500	\$2,500/\$8,500
Additional Hospital Deductible	N/A	N/A	N/A	N/A	\$1,000
Out-of-Area Child Additional Deductible	\$1,000	\$1,000	N/A		
Out-of-Pocket Maximum (Co-Ins limit) (Individual /Family)	\$1,500/\$4,500	\$2,500/\$7,500	\$6,350/\$12,700		Unlimited
Out-of-Pocket Maximum (Med & Rx) (Individual /Family)	\$8,150/\$16,300	\$8,150/\$16,300	\$8,150/\$16,300		Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited		
Preventive Care	No charge	No charge	No charge	No charge	N/A
Primary Physician	\$25	\$25	\$25	\$25	\$25*AD
Specialist Office Visit	\$50	\$50	\$50	\$50	\$50*AD
Out-of-Area Child Office Visit	20%*AD	20%*AD	N/A	N/A	N/A
Inpatient Hospital Services	15%	20%*AD	15%	40%*AD	60%*AD
Outpatient Hospital Services	15%	20%*AD	15%	40%*AD	60%*AD
Urgent Care**	\$30	\$30	\$30	\$30	\$30
Emergency Room Care	\$200 copay	\$200 copay	\$200 copay		

Note: This is a summary of your coverage only. Please refer to your summary plan description for the full scope of coverage. In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

*AD = After deductible is satisfied.

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.

****Urgent Care** - \$30 copay for services at SMH for employees living in Sarasota or Manatee Counties; or services provided at an Urgent Care outside of SMH, if living or traveling outside Sarasota or Manatee counties.

Medical Coverage

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 copayment or coinsurance 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/coverage/preventive-care-benefits/>

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 copay.

For more information visit:

www.gulfcoastmemberservices.org or call 941-917-2956.

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
- 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 Gulf Coast Medical Management.

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.



Prescription Drug Coverage

Prescription Drug Benefit

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**
 - You may have your prescription filled at any of the retail pharmacies that participate in the Navitus network. You will pay the appropriate copayment 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.

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.

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 multisource brand.

See more details at

www.gulfcoastmemberservices.org under Pharmacy Case Management.

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 \$1,500 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 Plan	Rx C	Rx B	Rx E
Prescription Drug Limitations			
Base Benefit	\$3,000	\$2,000	\$7,000
Coverage gap Per Participant	\$1,000	\$1,000	\$1,000
Umbrella Coverage	50%	50%	50%
Retail (30-day supply)			
Tier 1 (preferred generics)	\$9	\$9	\$9
Tier 2 (preferred brand)	40%, \$25 minimum	40%, \$25 minimum	40%, \$25 minimum
Tier 3 (non-preferred brand)	60%, \$35 minimum	60%, \$35 minimum	60%, \$35 minimum
Maximum Copay	\$75 per script	\$75 per script	\$100 per script
Specialty Drugs	\$100	\$100	\$100
Retail & Mail Order (90-day supply)			
Tier 1 (preferred generics)	\$20	\$20	\$20
Tier 2 (preferred brand)	40%, \$50 minimum	40%, \$50 minimum	40%, \$50 minimum
Tier 3 (non-preferred brand)	60%, \$75 minimum	60%, \$75 minimum	60%, \$75 minimum
Maximum Copay	\$75 per script	\$75 per script	\$100 per script
Compound Drugs	Follows Tier 3 copays up to a max of \$400 limit per 30-day supply. If total cost is >\$400, then Prior Authorization is required.		

Dental Plan

Your dental plan provides coverage for routine exams and cleanings and pays for a portion of other services, as shown in the chart below.

Your dental plan is provided through Aetna.

You have the choice of two 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)

Plan Provisions	Aetna Premium Plan	Aetna Standard Plan
Annual deductible per person	\$0	\$50 , applies to major svcs only
Annual Maximum per person	\$2,000	\$1,000
Diagnostic and Preventive, to include cleanings, sealants and x-rays	90% UCR	80% UCR
Basic Services to include fillings, periodontics, scaling and root planing, oral surgery	90% UCR	80% UCR
Major Services to include crowns, bridges, full and partial dentures	60% UCR	\$50 deductible then 50% UCR
Orthodontia	50% UCR \$1,000 Lifetime max	None

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.aetn navigator.com.

Discounts on hearing aid and batteries available through the plan



Vision Plan

Your vision plan provides coverage for routine exams and pays for all or a portion of the cost of glasses or contact lenses.

Your vision plan is provided through Aetna and provides benefits for routine eye exams, lenses and frames, and contact lenses.

Benefit	In-Network	Out-of-Network
Exam	\$10 copay	Up to \$30
Materials	\$15 copay	N/A
Frequency		
▪ Exam	12 months	12 months
▪ Lenses	12 months	12 months
▪ Frames	24 months	24 months
Frames	\$120 allowance + 20% off balance	Up to \$65
Lenses		
▪ Single	Covered in full after the materials copay	Up to \$25
▪ Bifocal		Up to \$40
▪ Frames		Up to \$60
Contacts		
▪ Fitting Fee	Standard: \$40; Premium: 10% off retail \$0	Not Covered
▪ Medically Necessary		Up to \$200
▪ Elective		
▪ Conventional	\$125 allowance + 15% off balance	Up to \$104
▪ Disposable	\$130 allowance	Up to \$104

Discounts and savings might be available on additional pairs of glasses and sunglasses, non-covered lens options, Laser Vision Correction, hearing aids and batteries.



Contact Information

RESOURCE	PHONE NUMBER	WEBSITE
Aetna Dental Plans	(877)238-6200	www.aetnavigators.com
Aetna Vision Plan	(877) 973-3238	www.aetnavision.com
Employee Assistance Program (EAP)	(877) 240-6863	www.HealthAdvocate.com/members
Gulf Coast Medical Management	(866) 260-0305	www.gulfcoastmemberservices.org
Gulf Coast Provider Network	(866) 260-0305	www.gulfcoastprovider.net
HealthFit	(941)917-7000	www.smhfit.com
Medical Plans (WebTPA)	(877) 697-2299	www.webtpa.com
Navitus Health Solutions	(866) 333-2757	Accessed through www.webtpa.com
NoviXus (Mail Order Rx)	(888) 240-2211	www.novixus.com
SMHCS Chronic Disease Case Manager	(941)917-2956	www.gulfcoastmemberservices.org
SMHCS Pharmacy Case Manager	(941)917-1473	www.gulfcoastmemberservices.org

Glossary

Understand the benefits terms that are used in your plan.

Brand Name Drugs: Drugs that have trade names and are protected by patents. Brand name drugs are generally the most costly choice.

Coinsurance: The percentage of a covered charge paid by the plan.

Copayment (Copay): A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible: The annual amount you and your family must pay each year before the plan pays benefits.

Generic Drugs: Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

In-Network: Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Out-of-Network: Use of a health care provider that does not participate in a plan's network.

Mail Order Pharmacy: Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

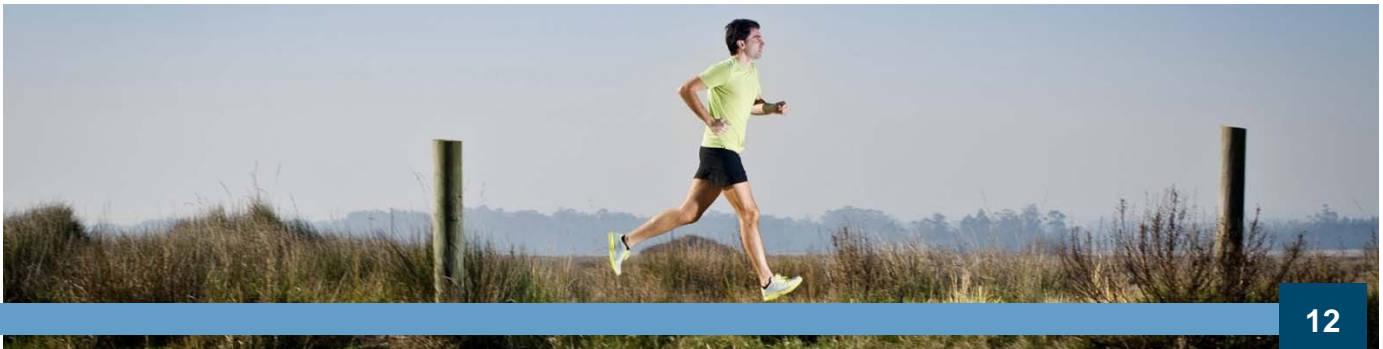
Inpatient: Services provided to an individual during an overnight hospital stay.

Outpatient: Services provided to an individual at a hospital facility without an overnight hospital stay.

Out-of-Pocket Maximum: The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year.

Primary Care Physician (PCP): Physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists as necessary.

Specialist: A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).



Important Notices

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

FLORIDA – Medicaid

Website: <http://flmedicaidplrecovery.com/hipp/>
Phone: 1-877-357-3268

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in the above state, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as January 31, 2019. Contact your State for more information on eligibility –

Important Notices

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

The Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact Human Resources.

Important Notices

Notice of Availability SMHCS Plan Notice of Privacy Practices

SMHCS (the “Plan”) provides health benefits to eligible employees of SMHCS (the “Company”) and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan’s duties and privacy practices with respect to covered individuals’ protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan’s Notice of Privacy Practices you should contact Human Resources.

Medicare Part D Creditable Coverage Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SMHCS and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. SMHCS has determined that the prescription drug coverage offered under the SMHCS Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current plan coverage will be affected. You can keep your coverage through SMHCS; however, the prescription drug coverage available through SMHCS plan will not coordinate with Medicare Part D.

If you decide to join a Medicare drug plan and drop your coverage through SMHCS, be aware that you and your dependents may not be eligible to enroll back into the SMHCS medical/prescription drug plan. This determination depends on your specific circumstances and is subject to the terms of the group health insurance policies in effect under the SMHCS Plan. Please contact Human Resources for further information.

Important Notices

Below is a description of the current prescription drug coverage offered through the SMHCS medical plan:

Prescription Plan	Rx C	Rx B	Rx E
Prescription Drug Limitations			
Base Benefit	\$3,000*	\$2,000*	\$7,000*
Coverage gap Per Participant	\$1,000	\$1,000	\$1,000
Umbrella Coverage	50%	50%	50%
Retail (30-day supply)			
Tier 1 (preferred generics)	\$9	\$9	\$9
Tier 2 (preferred brand)	40%, \$25 minimum	40%, \$25 minimum	40%, \$25 minimum
Tier 3 (non-preferred brand)	60%, \$35 minimum	60%, \$35 minimum	60%, \$35 minimum
Maximum Copay	\$75 per script	\$75 per script	\$100 per script
Specialty Drugs	\$100	\$100	\$100
Retail & Mail Order (90-day supply)			
Tier 1 (preferred generics)	\$20	\$20	\$20
Tier 2 (preferred brand)	40%, \$50 minimum	40%, \$50 minimum	40%, \$50 minimum
Tier 3 (non-preferred brand)	60%, \$75 minimum	60%, \$75 minimum	60%, \$75 minimum
Maximum Copay	\$75 per script	\$75 per script	\$100 per script
Compound Drugs	Follows Tier 3 copays up to a max of \$400 limit per 30-day supply. If total cost is >\$400, then Prior Authorization is required.		

*By working with the pharmacy case manager, you will receive an additional \$1,500 to your pharmacy cap

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SMHCS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SMHCS changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov OR call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 1-800- MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1- 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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GINA Warning against Providing Genetic Information

The Genetic Information Nondiscrimination Act (GINA) prohibits collection of genetic information by both employers and health plans, and defines genetic information very broadly. Asking an individual to provide family medical history is considered collection of genetic information, even if there is no reward for responding (or penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses. An employer administering a wellness program might include on the relevant forms a warning such as the one set out below.

Your Protections Under The Newborns' And Mothers' Health Protection Act (Newborns' Act)

If a group health plan, health insurance company, or health maintenance organization (HMO) provides maternity benefits, it may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

You cannot be required to obtain preauthorization from your plan in order for your 48-hour or 96-hour stay to be covered. (However, certain requirements that you give notice to the plan of the pregnancy or the childbirth may apply.)

The law allows you and your baby to be released earlier than these time periods only if the attending provider decides, after consulting with you, that you or your baby can be discharged earlier.

In any case, the attending provider cannot receive incentives or disincentives to discharge you or your child earlier than 48 hours (or 96 hours).

If your state has a law that provides similar hospital stay protections and your plan offers coverage through an insurance policy or HMO, then you may be protected under state law rather than under the Newborns' and Mothers' Health Protection Act.

General Notice of COBRA Continuation Coverage Rights

Introduction

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

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

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

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What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
 - The parent-employee dies;
 - The parent-employee’s hours of employment are reduced;
 - The parent-employee’s employment ends for any reason other than his or her gross misconduct;
 - The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
 - The parents become divorced or legally separated; or
 - The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to SMHCS and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;

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- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: SMH Benefits Department at 1852 Hillview Street, Sarasota, FL 34239.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Contact SMH Benefits Department at 941-917-6177 for further information regarding this benefit.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group

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health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

SMH Benefits Department, 1852 Hillview Street, Sarasota, FL 34239 or 941-917-6177

Notice of Extended Coverage to Participants Covered Under a Group Health Plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

The **Sarasota Memorial Health Care System Medical Plan** (the "Plan") currently permits an employee to continue a child's coverage to the end of the month in which the child turns 30, if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child* means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- *Medically necessary leave of absence* means a leave of absence or any other change in enrollment:
 - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury
 - which is medically necessary
 - and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility). If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

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About This Guide

This benefit summary provides selected highlights of the SMHCS employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. SMHCS reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.