THE CITY OF NEW PORT RICHEY FLORIDA

2025 - 2026 Benefits Guide

Effective October 1, 2025 – September 30, 2026

WELCOME TO YOUR BENEFITS

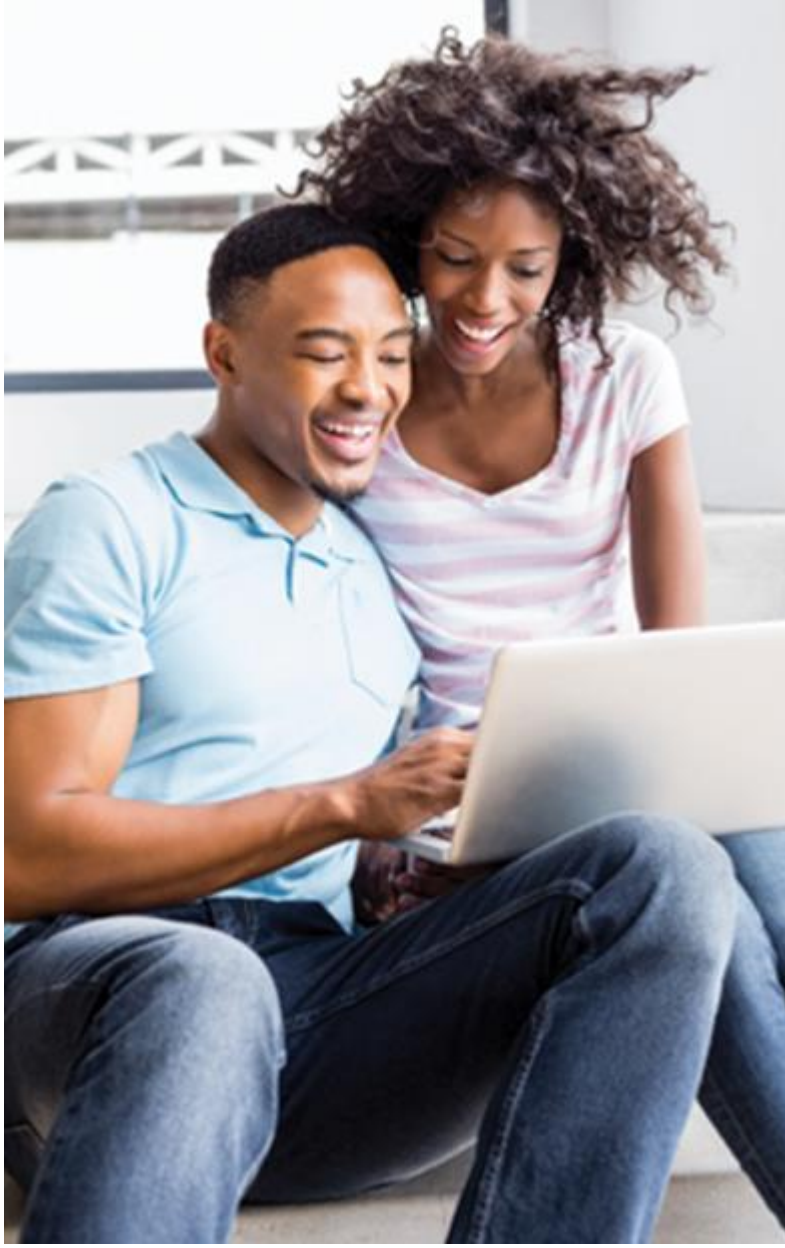
Our most important asset is our people. That's why the City of New Port Richey offers a comprehensive benefits program to meet all your needs. Review this guide to learn about the benefits you are offered and to determine which benefits are best for you and your family. You will find many resources available during enrollment and throughout the year to help you make the most of your benefit plans and answer your questions.

The health care coverage you elect begins with your initial eligibility date and continues through the end of the enrollment year. The City's health care benefit year begins October 1st and ends September 30th. You may also enroll or change your benefits during the annual Open Enrollment period.

You must confirm your benefit choices through **Benefitfirst** by the appropriate deadline to have coverage. If you miss the enrollment window, you will have to wait until the next annual enrollment to elect benefits or make changes, unless you experience a qualifying life event. Keep reading this guide for more information.

WHAT'S INSIDE

CONTACTS & RESOURCES



You can find more details about the benefits offered to you by logging in to our new enrollment portal, **Benefitfirst**, or by contacting the insurance carriers directly. Enrollment instructions are on page 6.

Register on the insurance carrier websites to access plan information, including your ID cards, coverages, claims, network providers, and more. Search for the carrier apps on Google Play™ or the App Store® to access your benefits information anytime, anywhere from your mobile device.

If you have any questions about your benefits or need assistance with enrolling, you may contact **Dana Cliver at cliverd@cityofnewportrichey.org or 727-853-1025**. If technical questions with enrolling and/or the site, please call 888-682-4886 to speak with a **Benefitfirst** Representative.

BENEFIT	CARRIER	PHONE	WEBSITE
Medical Benefits	Florida Blue	877-352-2583	floridablue.com
Virtual Care	Teladoc	1-800-TELADOC	teladochealth.com
Health Savings Account	HSA Bank	1-866-357-5232	hsabank.com
Flexible Spending Accounts	Ameriflex	888-868-3539	myameriflex.com
Dental Benefits	MetLife	800-942-0854	mybenefits.metlife.com
Vision Benefits	MetLife	855-638-3931	mybenefits.metlife.com
Life and AD&D Insurance	MetLife	800-523-2894	mybenefits.metlife.com
Disability Insurance	MetLife	800-858-6506	mybenefits.metlife.com
Supplemental Insurance	MetLife	1-800-438-6388	mybenefits.metlife.com
EAP / Grief Counseling	MetLife / TELUS Health	1-888-319-7819	one.telushealth.com

BENEFITS ELIGIBILITY

WHO CAN ENROLL

Employees: All regular full-time employees working at least 30 hours per week are eligible for all City benefits. Retirees are eligible for medical and dental benefits only.

Dependents: You may enroll the following dependents in our group benefit plans:

- Your legal spouse
- Your natural, adopted, or step children who live with you, or any other children with whom you have legal guardianship, up to age 26. Unmarried dependent children, under the age of 30 are eligible for extended medical coverage if they are unmarried, do not have dependents of their own, reside in Florida, are a student, and do not have other health insurance coverage. Coverage for these dependents would end the last day of the calendar year in which they turned 30.
- Unmarried children of any age if disabled and claimed as a dependent on your federal income taxes

WHEN YOU CAN ENROLL

During Open Enrollment: The annual Open Enrollment period is your opportunity to make changes to your current elections or to elect benefits for the first time if you did not do so as a new hire. Benefits elected during Open Enrollment will go into effect on October 1st.

As a New Hire: New hires may enroll in benefits on the first day of the month following 30 days of employment. You must make your elections during the allowed timeframe, or you will have to wait until the next Open Enrollment period to elect coverage, unless you experience a qualifying life event.

WHEN COVERAGE ENDS

If you leave your job, your medical, dental, and vision coverage will terminate on the last day of the month following the last day worked. All other benefits will terminate on the last day worked.

MAKING CHANGES TO YOUR BENEFITS

Outside of your initial new hire or the annual Open Enrollment period, changes to your benefits can **only** be made throughout the year within 30 days of a qualifying life event.

Examples of the most common qualifying life events include:

- Marriage or divorce
- Birth or adoption of an eligible child
- Death of a covered dependent
- Change in your spouse's work status that affects your benefits
- Change in your work status that affects your benefits
- Change in residence that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receipt of a Qualified Medical Child Support Order (QMCSO)

To report a qualifying life event, please contact Human Resources. Documentation may be required.

If you fail to report a life event and do not supply the necessary documentation, you will be required to wait until the next annual enrollment period to make changes.

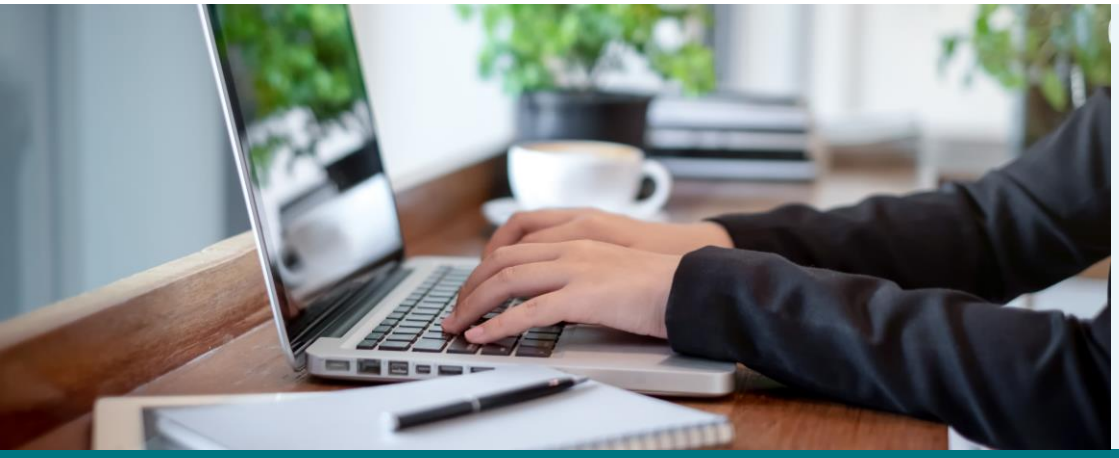
ENROLLMENT INSTRUCTIONS

Our new benefits portal, **Benefitfirst**, enables you to make your benefit elections whenever and wherever it is most convenient. This site will guide you, step-by-step, through the enrollment process. For each benefit, you will be able to review your choices, if applicable, select your coverage level, and include any dependents you want to cover for that benefit.

Follow the steps below to log in and make your benefit elections:

1. Log on at benefitfirst.com OR via the mobile app.
2. Enter the Company ID = ***1207***.
3. Create a User ID and password.
4. Log in and follow the instructions.
   - » Enter your name as it appears on your paycheck and your date of birth in the following format: ***MM/DD/YYYY***.
   - » Choose a unique, confidential password and click ***Submit***.
   - » On the homepage, click ***Enroll Now***.
   - » If you are a new hire, choose ***Enroll in*** or ***Decline Benefits as a Newly Eligible Employee***.
   - » If you are an existing employee, choose the appropriate transaction (open enrollment or family status change) and click ***Continue***.
   - » Check your personal information for accuracy and click ***Next***.
   - » Add any eligible dependents to the dependent screen and click ***Next***.
   - » Complete your selections starting with the medical screen. Choose the level of coverage, the plan desired, and the dependents to be included/added.
   - » At the final enrollment screen, you will be required to review your elections and certify them by re-entering your password.
   - » The final step is to click the ***Submit*** button. The entire process can take as little as 4 minutes to complete.

Scan the QR code to access the **Benefitfirst** *website*



NEED HELP?

Need an explanation of insurance terms or help deciding between your benefit options? Visit the Decision Support Center on your **Benefitfirst** homepage for a library of frequently asked questions.

WHERE TO GO FOR CARE

The cost of care and time you wait can vary greatly depending on where you go for care. Below is a simple guide to choosing the right place for health care. In addition to clinical settings, you have access to virtual visits through Teladoc.

24/7 NURSELINE

If an unexpected medical situation arises, a nurse can help you decide if you should call your doctor, visit the ER or urgent care, or treat the problem yourself. A nurse can also let you know if you can wait to see the doctor the next day.

DOCTOR'S OFFICE

Your primary care physician (PCP) should be your first choice for non-emergency care and ongoing health conditions. Your PCP knows your medical history and can help manage chronic conditions and recommend specialists or other medical care.

VIRTUAL VISIT

If your doctor isn't available, you are out of town, or you need care after hours for a simple condition, try a virtual visit. Go online or access the app to make an appointment with a physician anytime, 24/7, wherever you are.

URGENT CARE AND RETAIL CLINICS

If your doctor isn't available or you need care after hours for a non-life-threatening issue, visit an urgent care or retail health clinic for simple conditions such as a cold or the flu. Urgent care centers can provide a greater range of care, including X-rays.

EMERGENCY ROOM

Only visit the ER for serious, life-threatening medical care. If you feel you are dealing with a health emergency, call 911 or go to the ER right away. Do **not** visit the Emergency Room for routine care or minor ailments.

Please see page 11 for contact information to include website and phone numbers.

MEDICAL BENEFITS

City employees have the choice between three medical plans offered through Florida Blue: two traditional PPO plans and a High Deductible Health Plan (HDHP) that is compatible with a Health Savings Account (HSA). These plans offer services on the Blue Options Network.

- You do not need to designate a primary care physician.
- You do not need a referral to see a specialist.
- For bloodwork, use Quest. Test costs are covered by the plan
- Refer to the Florida Blue Provider Directory for out-of-state providers/care.

All plans offer preventive care visits covered at 100%, an out-of-pocket maximum to protect you should a catastrophic event occur, and out-of-network coverage if needed. Although out-of-network coverage is available, using in-network providers will save you money. You can find Florida Blue network providers online at floridablue.com.

HDHP VS. PPO PLAN

PPO

- Copays for office visits; coinsurance pays after deductible is met
- Premiums are typically higher
- In and out-of-network coverage
- Not HSA eligible
- Health & Dependent Care FSA eligible

HDHP

- You pay out-of-pocket for all visits and services until deductible is met
- Premiums are typically lower
- In and out-of-network coverage
- HSA eligible
- Dependent Care FSA eligible only

MEDICAL PLAN COMPARISON

IN-NETWORK	HDHP + HSA[1]	BLUE OPTIONS 5000	BLUE OPTIONS 1500
Calendar Year Deductible	$3,500 / $7,000*	$5,000 / $10,000	$1,500 / $4,500
Coinsurance	20% after deductible	30% after deductible	20% after deductible
Out-of-Pocket Max	$7,000 / $14,000*	$6,350 / $12,700	$4,500 / $9,000
Preventive Care	Covered in full	Covered in full	Covered in full
Office Visits			
» Primary care	$30 copay after deductible	$30 copay	$30 copay
» Specialist	$75 copay after deductible	$55 copay	$55 copay
» Urgent Care	$100 copay after deductible	$60 copay	$60 copay
Emergency Room (Facility)	$350 copay after deductible	$300 copay	$250 copay
Inpatient Hospital	20% after deductible	30% after deductible	20% after deductible
Outpatient Surgery			
» Facility Fee	20% after deductible	30% after deductible	Ambulatory Surgery Center: $200 copay per visit Hospital: 20% after deductible
» Physician/Surgeon Fees	20% after deductible	30% after deductible	Ambulatory Surgery Center: $55 copay per visit Hospital: 20% after deductible
Outpatient Diagnostic			
» Labs	20% after deductible	Covered in full	Covered in full
» X-rays	20% after deductible	30% after deductible	$50 copay
Major Diagnostics	20% after deductible	30% after deductible	$250 copay

OUT-OF-NETWORK			
Deductible	$7,000 / $14,000	$10,000 / $30,000	$4,500 / $13,500
Coinsurance	40% after deductible	50% after deductible	50% after deductible
Out-of-Pocket Max	$13,700 / $27,400	$20,000 / $40,000	$9,000 / $18,000

[1]Employer HSA contribution: $1,200 during the plan year.
**$7,000 per individual with dependents enrolled.*

BI-MONTHLY PAYROLL DEDUCTIONS

NON-SMOKER	HDHP + HSA	BLUE OPTIONS 5000	BLUE OPTIONS 1500
Employee Only	$24.01	$47.80	$81.50
Employee + Spouse	$75.57	$140.77	$185.50
Employee + Child(ren)	$69.93	$122.00	$163.00
Employee + Family	$136.83	$211.50	$260.00
SMOKER			
Employee Only	$150.09	$183.86	$224.70
Employee + Spouse	$301.73	$369.79	$438.48
Employee + Child(ren)	$285.15	$349.64	$414.58
Employee + Family	$481.91	$590.88	$700.71

PRESCRIPTION BENEFITS

When you enroll in a medical plan, you are automatically enrolled in prescription drug coverage. Florida Blue's contracted partner, Prime Therapeutics, helps to administer your prescription drug benefits. Prescription drug coverage varies by plan to offer affordable choices for everyone. So, it's important to understand your plan's prescription drug coverage - from covered drugs and coverage requirements to cost shares and pharmacy choices.

SPECIALTY MEDICATIONS

Specialty drugs require prior authorization and must be obtained through Caremark Specialty Pharmacy. Call 1-866-387-2573.

If you regularly take the same medications, a mail-order program may allow you to get a 90-day supply for a lower cost, saving you trips to the pharmacy and time waiting in line. Always discuss lower-cost alternatives with your physician and check the insurance company's website for a complete drug list. If your prescription is not covered, discounts may be available through the BlueSaver discount program.

Log in to your account to get plan-specific benefits and costs, which makes it easier to compare options with your doctor or pharmacist.

- Call: Contact a Care Consultant at 1-888-476-2227.
- Click: Log in at floridablue.com and select *Compare Drug Prices* under *Tools*.
- Visit: Find a Florida Blue Center near you at floridablue.com.

PRESCRIPTION DRUGS	HDHP + HSA	BLUE OPTIONS 5000	BLUE OPTIONS 1500
Deductible	Combined with medical	None	None
Retail Rx (30 days)			
» Tier 1 Generic	$10 copay after deductible	$10 copay	$10 copay
» Tier 2 Preferred	$50 copay after deductible	$50 copay	$50 copay
» Tier 3 Non-preferred	$80 copay after deductible	$80 copay	$80 copay
» Tier 4 Specialty	$250 copay after deductible	$250 copay	$250 copay
Mail Order (90 days)			
» Tier 1 Generic	$25 copay after deductible	$25 copay	$25 copay
» Tier 2 Preferred	$125 copay after deductible	$125 copay	$125 copay
» Tier 3 Non-preferred	$200 copay after deductible	$200 copay	$200 copay

MEDICAL PLAN RESOURCES

FLORIDA BLUE MEMBER WEBSITE & MOBILE APP

Florida Blue's updated member website is easier than ever for you to use, helping you get what you need quickly and without any fuss. From finding a doctor to understanding your benefits, it's all at your fingertips. The new *My Account* section lets you easily update important details, like your personal information, your communication preferences (email, text, regular mail, etc.), caregiver information, and more:

- View your benefits and coverages
- Find a doctor or facility
- Track your health goals and get support
- Boost your mental well-being
- Earn rewards and discounts

Register for your account at floridablue.com and download the Florida Blue app. You can use the same username and password to log in to both places.

TELADOC VIRTUAL CARE

Visit a doctor virtually using your mobile device, tablet, or computer 24/7 while enrolled in any of the Florida Blue medical plans. Virtual visits are ideal for things like bronchitis, colds or flu, fever, rash, sinus problems, sore throat, stomachaches, and more. A doctor will give you a diagnosis and, if necessary, a prescription. Visit teladochealth.com or call 1-800-TELADOC.

BETTER YOU STRIDES WELLNESS PROGRAM

Better You Strides is a free online wellness program that uses your needs, goals, and interests to build a customized plan to improve your health. You can also participate in rewards, which can help pay for your health premiums or medical costs.

To register, log in to your Florida Blue online account at floridablue.com, click *Your Guide to Better Health* on the right side of the home page, then click *Get Started*. Follow the prompts to create your account.

NURSES ON CALL

For advice 24/7, the Florida Blue Nurseline is available for general health and prevention questions or for education and support on medical issues like diabetes, heart disease, or surgeries. Call 1-877-789-2583.

HEALTHY ADDITION PRENATAL PROGRAM

The Healthy Addition program works with you and your health care provider to help you have a healthy pregnancy. For more information, email healthyaddition@floridablue.com or call 800-955-7635, option 6, Monday through Friday, 8 a.m. to 5:30 p.m. EST.

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) allows you to set aside money to pay for qualified healthcare expenses. Because your contributions are deducted pre-tax, you can save up to an estimated 25% on out-of-pocket costs. When you enroll in a High Deductible Health Plan (HDHP), the City will open an account for you with HSA Bank, and you will receive a debit card in the mail.

To participate in an HSA, you must:

- Be enrolled in a qualified HDHP
- Not be covered by any other non-HSA-qualified health plan
- Not be enrolled in Medicare
- Not be eligible to be claimed as a dependent on someone else's taxes
- Not be enrolled in a standard Health care FSA while actively contributing to your HSA

HOW IT WORKS

You determine the amount to be deducted from each paycheck. The funds are automatically deposited into your account. Unused funds carry over from year to year and can build up over time. HSAs are portable; if you leave the City, you can take the account and all the funds in it with you.

CONTRIBUTION LIMITS

The Internal Revenue Service (IRS) sets the annual contribution levels for HSAs. It is your responsibility to monitor the amounts deposited and not exceed the maximum limit.

	2025	2026
Individual	$4,300	$4,400
Family	$8,550	$8,750

Eligible individuals aged 55 and older may contribute an additional $1,000 annually. You have until the following year's tax filing deadline to contribute in the current plan year.

ELIGIBLE EXPENSES

Use your HSA funds to pay for health care items such as copays, prescriptions, home care, medical supplies and equipment, and other out-of-pocket expenses your insurance may not cover. You may also use these funds for dental and vision expenses, counseling, chiropractic care, physical therapy, certain OTC medications, and more. Visit irs.gov/forms-pubs/about-publication-502 to see a complete list of IRS-qualified expenses.

Did You Know

If you are electing family coverage on your high-deductible health plan and covering a spouse that is 55 years of age or older that there is a $1000 catch up for them too? Your spouse must open their own HSA to contribute their $1000 catch up contribution. It is available to them every year they are covered by your HDHP and are 55+.

If you are electing family coverage with your high-deductible health plan and covering an adult child who is no longer claimed on another person's tax return, that adult child can open their OWN HSA? That child can contribute up to the family limit while they are on your HDHP and not claimed as a deduction on another person's tax return.

FLEXIBLE SPENDING ACCOUNTS

The City offers Flexible Spending Accounts (FSAs) through Ameriflex. FSAs help you pay for eligible medical, dental, vision, and dependent care out-of-pocket costs by allowing you to set aside pre-tax contributions. Health Care FSA funds are available to use as of October 1st, even money you have not contributed yet. Dependent Care funds are only available as you contribute.

WHO CAN ENROLL

The Health Care FSA is available only to employees who enroll in one of the PPO plans. All employees are eligible to enroll in the Dependent Care FSA.

You will receive a debit card from Ameriflex that can be used to pay for out-of-pocket health care expenses. The debit card may not be used to pay for dependent care expenses.

HOW IT WORKS

You determine the amount you wish to have deducted from each paycheck, and the funds are automatically deposited into your account(s). You may only use Health Care FSA money for health care expenses and Dependent Care FSA for funds for dependent care expenses. You can not mix funds from one account to another. **You must re-enroll each year to continue funding the account(s), and you can incur expenses only during the plan year you are enrolled. Unused health care amounts over $660, and all unused dependent care funds will be forfeited, so estimate wisely.**

CONTRIBUTION LIMITS

The Internal Revenue Service (IRS) sets the annual contribution levels for FSAs. You are responsible for monitoring the amounts deposited into your accounts, not to exceed the maximum annual limits.

For 2025, the FSA contribution limits are:

- Health Care FSA: $3,300
- Dependent Care FSA: 5,000 per household ($2,500 if married, filing separately)

ELIGIBLE EXPENSES

Use your Health Care FSA funds to pay for out-of-pocket medical, dental, hearing, and vision expenses such as copays, prescriptions, supplies, appliances, and some OTC items. Visit irs.gov/forms-pubs/about-publication-502 to see a complete list of IRS-qualified healthcare expenses.

Use Dependent Care FSA funds to pay for qualified daycare expenses for children aged 12 and younger and a spouse or an adult-dependent incapable of self-care. Eligible expenses include daycare, preschool, summer day camp, elder care, and in-home aids. Visit irs.gov/publications/p503 to see a complete list of IRS-qualified dependent care expenses.

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DENTAL INSURANCE

The City offers dental coverage through MetLife, with two plans to choose from: a Dental HMO plan and a traditional PPO plan. Out-of-network benefits are only available with the PPO plan. However, when you visit an out-of-network provider, you will be responsible for paying the difference between the allowed amount and what the dentist may charge, also known as "balance billing."

To find network providers, go to metlife.com, scroll down to *Find a Dentist*, and then select either the *Dental HMO/Managed Care* or *PDP Plus* network. You do not need an ID card to see a dentist. The provider will verify your benefits using your Social Security Number.

IN-NETWORK	DHMO PLAN	PPO PLAN
Annual Deductible	None	$50 Individual / $150 Family
Annual Plan Maximum	None	$1,000 per member
Preventive Services Routine exams, cleanings, X-rays (bitewing), fluoride, etc.	Copays: $5 office visit	Covered in full
Basic Services Fillings, simple extractions, etc.	Copay schedule	Plan pays 80% after deductible
Major Services Inlays, onlays, dentures, implants, surgical extractions, oral surgery, endodontics, periodontics, etc.	Copay schedule	Plan pays 50% after deductible
Orthodontia	Discount available	Not covered

Out-of-network services on the PPO plan are covered at the same percentage as in-network, plus any balance over the Usual & Customary Charge.

BI-MONTHLY PAYROLL DEDUCTIONS

PREMIUMS	DHMO PLAN	PPO PLAN
Employee Only	$5.14	$12.97
Employee + 1	$8.99	$26.00
Employee + Family	$13.27	$41.19

VISION INSURANCE

The City offers vision coverage through MetLife. The plan allows you to use in-network or out-of-network providers. However, when using out-of-network providers, you will pay expenses at the time of service and file a claim for reimbursement.

To find in-network providers, visit metlife.com, click *Find a Vision Provider*, and enter your zip code, city, and state. Or you may log in to your MetLife account at mybenefits.metlife.com. You do not need an ID card to see a vision provider. Your benefits will be verified using your Social Security number and date of birth.

PLAN HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Eye Exam	$10 copay	Up to $45
Eyeglass Lenses	$15 copay	$30 - $100
Eyeglass Frames	$100 allowance + 20% off balance	Up to $55
Contact Lenses		
» Elective	$100 allowance	$80
» Medically necessary	$15 copay	$210
Frequency of Services	Eye exam, eyeglass lenses OR contact lenses: every 12 months; Frames: every 24 months	

When using out-of-network providers, you must pay full price at the time of service and then submit a claim to MetLife for reimbursement up to the plan allowances.

BI-MONTHLY PAYROLL DEDUCTIONS

PREMIUMS	VISION PLAN
Employee Only	$2.49
Employee + 1	$4.76
Employee + Family	$7.74

LIFE AND AD&D INSURANCE

COMPANY-PAID BASIC LIFE AND AD&D

The City provides each employee with Basic Life and Accidental Death & Dismemberment (AD&D) insurance through MetLife and pays for the full cost of the benefit. Eligible employees receive $10,000 in both the Basic Life and AD&D coverage. Benefit amounts are reduced by 35% at age 65, 60% at age 70, and 80% at age 75. If you leave employment with the City, the policy may be converted to an individual policy. For these and other plan details, refer to the Certificate of Coverage, which can be found on **Benefitfirst**.

Beneficiaries: It is essential to ensure that your beneficiary information is correct at enrollment and throughout the year. Log in to **Benefitfirst** or contact HR to update this information anytime.

VOLUNTARY LIFE AND AD&D

City employees may supplement their company-paid Basic Life insurance by purchasing additional coverage through MetLife. After electing coverage for themselves, employees may also elect coverage for their spouse and child(ren). The following benefit amounts are available for you and your dependents. Your cost for coverage can be calculated when making your elections on **Benefitfirst**.

EMPLOYEE	SPOUSE	CHILD(REN)
Increments of $10,000 to $500,000 or 7x your pay, whichever is less	Increments of $5,000 to $100,000 or 50% of employee amount, whichever is less	Ages 6 months to 26: Options of $1,000, $2,000, $4,000, $5,000 or $10,000
Guarantee Issue: $150,000	Guarantee Issue: $50,000	Guarantee Issue: $10,000

GUARANTEE ISSUE

The Guarantee Issue (GI) amount is the highest amount of coverage that you or your dependents may elect without completing an Evidence of Insurability (EOI) form. You may elect coverage up to the GI limits above without completing an EOI when you are first eligible for benefits. If you choose to elect an amount above the GI limit or increase your benefit amount at a future date, the coverage amount over the GI level will **not** go into effect until your EOI has been reviewed and approved, and payroll deductions have begun. For full details, refer to the Certificate of Coverage.

DISABILITY INSURANCE

Whether you are disabled and unable to work due to an accident or illness, the City offers Voluntary Short and Long-Term Disability benefits options through MetLife. Disability coverage is insurance for your paycheck should you become disabled due to an off-the-job injury or illness. This coverage will provide a percentage of your salary once you satisfy the waiting period. Your cost for disability coverage can be calculated when making your elections on **Benefitfirst**.

VOLUNTARY SHORT-TERM DISABILITY

The City offers employees the opportunity to purchase Voluntary Short-Term Disability insurance. The benefit would pay 60% of your weekly pre-disability earnings to a maximum of $1,000 per week for up to 26 weeks or until you no longer meet the definition of disability, whichever occurs first. Benefits begin to pay on the 1st day for an accident and on the 8th day for an illness.

Pre-Existing Condition Limitation

Any Short-Term Disability claim filed during the first 12 months of coverage is subject to the pre-existing condition lookback period of 3 months prior to the effective date of coverage.

VOLUNTARY LONG-TERM DISABILITY

The City also offers employees the option to purchase Voluntary Long-Term Disability (LTD) in addition to Voluntary Short-Term Disability. After a 180-day waiting period, the benefit would pay 60% of your monthly pre-disability earnings to a maximum of $5,000 per month until you no longer meet the definition of disability or reach the Social Security Normal Retirement Age (SSNRA).

Pre-Existing Condition Limitation

If you become disabled during the first 12 months you are enrolled in the Long-Term Disability plan, and that was due to a pre-existing condition, it won't be covered. A pre-existing condition is a condition/symptom that you were treated for, consulted with a physician, or took prescribed medications in the 6 months immediately prior to your effective date.

The plan will cover expenses during this period that are not related to a pre-existing condition. Claims incurred due to a pre-existing condition will be covered after you have been enrolled in the plan for 12 months.

PLAN HIGHLIGHTS	SHORT-TERM DISABILITY	LONG-TERM DISABILITY
Elimination Period	Accident: 0 days / Illness: 7 days	180 days
Percentage of Income Replaced	60% of weekly earnings	60% of monthly earnings
Benefit Maximum	$1,000 per week	$5,000 per month
Benefit Duration	Up to 26 weeks	SSNRA

SUPPLEMENTAL INSURANCE

The City offers employees the option to purchase supplemental insurance, including Hospital Select, Accident, and Critical Illness insurance, provided through MetLife. In addition, you have the option to cover your spouse and child(ren) after electing coverage for yourself. You must elect coverage for yourself before selecting coverage for your spouse or child(ren). The premiums will be deducted from your paycheck. Refer to the MetLife plan documents on **Benefitfirst** for details, including covered services, exclusions, and limitations.

VOLUNTARY ACCIDENT

Where most medical plans only pay a portion of the bills, Voluntary Accident Insurance can help pick up where other insurance leaves off. This policy provides a cash benefit to cover expenses if you or a covered dependent experiences an eligible event.

Employees can receive reimbursement for covered events, including:

- Emergency care benefit
- Non-emergency initial care and physician follow-up
- Hospital admission and confinement
- Accidental death benefit
- Organized sports injury benefit

BI-MONTHLY	ACCIDENT PLAN
Employee Only	$4.98
Employee + Spouse	$11.38
Employee + Child(ren)	$10.11
Employee + Family	$18.26

The policy also pays a $100 annual wellness benefit when you and your covered dependents complete a qualified screening. For more information, refer to the policy documents.

VOLUNTARY HOSPITAL SELECT

A hospital admission can result in significant financial hardship. You may have a large deductible to meet in addition to other hospital-related charges for surgery, anesthesia, radiology, and more. A Voluntary Hospital Indemnity policy provides a lump sum cash benefit paid directly to you to help offset those expenses not covered by your major medical insurance. Reimbursement increases with the number of days you are hospitalized.

The plan pays benefits for initial hospitalization, hospital confinement, rehabilitation unit, newborn nursery care, and more. You may use the benefits any way you choose, including day-to-day living expenses, to help reduce the stress caused by a hospitalization, so you can focus on recovery.

BI-MONTHLY	HOSPITAL PLAN
Employee Only	$12.06
Employee + Spouse	$24.78
Employee + Child(ren)	$20.61
Employee + Family	$35.40

VOLUNTARY CRITICAL ILLNESS

Voluntary Critical Illness Insurance pays a lump sum cash benefit when you or a covered family member is diagnosed with a serious illness, such as a heart attack, stroke, major organ failure, or cancer. You may use this benefit in any way you choose to pay for expenses that are not medical but have occurred due to the diagnosis, such as lost wages, family care, rehabilitation, or transportation.

The plan provides coverage for you and your family in the following amounts:

- Employees: Lump sum benefit of $10,000 or $20,000 with no medical questions
- Spouse and Children: 50% of employee benefit amount based on employee's age, benefit amount, and tobacco usage.

The plan does not have a pre-existing condition limitation and offers immediate value through an annual wellness screening benefit of $100 each for the employee and their spouse. Your cost for coverage is based on age, tobacco usage, and benefit level, and can be calculated when making your benefit elections on **Benefitfirst**

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HOW TO FILE AN ACCIDENT, HOSPITAL, OR CRITICAL ILLNESS CLAIM

Step 1: Confirm your Plans and Options for Benefit Payments
Call the MetLife Claims Customer Service Center for claims and policy details at 1-800-Get-Met8 or 1-800-438-6388, Monday – Friday from 8:00 a.m. to 8:00 p.m. EST, or visit mybenefits.metlife.com.

The Customer Service Center will provide you with the claim forms, instructions on where to send them, and the required supporting documents such as your Explanation of Benefits (EOBs), a copy of lab or x-ray reports, ambulance bill, or other relevant documents.

Step 2: Submit your Claim to MetLife
The fastest way to submit your claim is online at mybenefits.metlife.com. You may also call 1-800-438-6388 or download the MetLife mobile app to initiate a claim. Once your claim is approved, you will receive a check.

ADDITIONAL BENEFITS

EMPLOYEE ASSISTANCE PROGRAM

All full-time employees are automatically provided access to the MetLife Employee Assistance Program (EAP) powered by TELUS Health at no cost. These benefits are available to you and your family members who live with you. Expert advice is available to you 24 hours a day, 7 days a week, 365 days a year, and the program is completely confidential.

Experienced counselors with TELUS Health can help with a variety of questions and concerns, including family issues, work issues, financial advice, identity theft recovery, anxiety and depression, or just everyday life. The program includes up to five (5) phone or video consultations with a licensed counselor for you and your eligible household members per year.

For assistance or to learn more, call 1-888-319-7819 and select *Employee Assistance Program* when prompted, or visit one.telushealth.com and enter the username ***metlifeeap*** and password ***eap***. You can also download the TELUS Health mobile app to access your EAP benefits anytime using your mobile device.

GRIEF COUNSELING

Grief counseling services through TELUS Health are available to you with your MetLife life insurance coverage. Professional counselors can provide confidential support to you and your family during difficult times, such as when a loved one has passed, a divorce is finalized, or a serious medical diagnosis has been made. These counseling sessions are tailored to help meet your individual needs. Up to five (5) in-person or telephonic sessions are available with a licensed TELUS Health counselor.

The program also provides resources to help you navigate difficult times, including online self-help resources and funeral assistance services that can assist with funeral planning, adult and child care, and more. Contact TELUS Health at 1-888-319-7819 for assistance or to learn more, or visit one.telushealth.com.

TIME OFF FROM WORK

****Represented employees should refer to their respective Collective Bargaining Agreements for differences and specific details.****

PAID TIME OFF

Below is the schedule for annual leave accrual for regular full-time, permanent employees. If you have questions, please contact Human Resources.

YEARS OF SERVICE	40 HOURS/WEEK	56 HOURS/WEEK
Up to 5 years	12 days per year	6 shifts per year
5 years	13 days per year	7 shifts per year
6 years	14.1 days per year	8 shifts per year
7 years	15 days per year	8 shifts per year
8 years	16 days per year	8 shifts per year
9 years	17.1 days per year	8 shifts per year
10 years+	18 days per year	9 shifts per year

Sick/Medical Leave: **40-Hour Work Week -** 96 working hours per year. **56-Hour Work Week -** 144 working hours per year (each workday 24 hours).

Personal Leave: 1-4 years of employment – 8 hours; 5+ years of employment - 16 hours.

HOLIDAYS

The City of New Port Richey observes the following holidays for regular employees for 2025-2026:

- Labor Day – Monday, September 1, 2025
- Veteran's Day – Tuesday, November 11, 2025
- Thanksgiving Day and the day after Thanksgiving – Thursday, November 27 and Friday, November 28, 2025
- Christmas Eve – Wednesday, December 24, 2025 (half day)
- Christmas Day – Thursday, December 25, 2025
- New Year's Eve - Wednesday, December 31, 2025 (half day)
- New Year's Day – Thursday, January 1, 2026
- Martin Luther King Jr. Day – Monday, January 19, 2026
- Good Friday – Friday, April 3, 2026
- Memorial Day – Monday, May 25, 2026
- Juneteenth – Friday, June 19, 2026
- Independence Day – Friday, July 3, 2026
- Labor Day – Monday, September 7, 2026
- Veteran's Day – Wednesday, November 11, 2026
- Thanksgiving Day and the day after Thanksgiving – Thursday, November 26 and Friday, November 27, 2026
- Christmas Eve – Thursday, December 24, 2026 (half day)
- Christmas Day – Friday, December 25, 2026

Floating Holiday: 24 hours (3 days) on annual anniversary date.

TERMS TO KNOW

Deductible: The amount an employee pays out of pocket before the insurance company pays a percentage of the provider charges.

Coinsurance: The amount of payment split between the employee and the insurance company. Example: The insurance company pays 80%, and the employee pays 20% of the charges after you meet the deductible.

Out-of-Pocket Maximum: The maximum amount an employee is responsible for paying out of pocket in any calendar year before the insurance the company pays the entire eligible amount for the remaining calendar year.

Network Providers: Doctors, hospitals, and other health care providers with an agreement/contract with insurance companies agreeing to charge a discounted amount for services rendered.

Pre-Authorization: Certain procedures or hospitalizations may require that the provider receive authorization. The provider is typically the one to go through this process with the insurance company and obtain pre-authorization.

Explanation of Benefits (EOB): The EOB is mailed to the employee after the insurance company receives and processes a claim. It describes how the claim was processed, outlines which portion of the charges has been applied to the deductible, what amount the employee is responsible for, and explains if there was a denial or error in processing the claim.

Appeal: If your health insurance company doesn't pay for a specific health care provider or service, you have the right to appeal the decision and have it reviewed by an independent third party.

Guarantee Issue: The maximum amount of voluntary life insurance you can choose when making your initial election, which does not require answering medical questions.

Evidence of Insurability (EOI): The form containing medical questions you must answer if you decide to elect voluntary life insurance after you have previously declined coverage and/or wish to increase your current coverage later. The form may also be required if you add disability coverage after previously declining such coverage..

IMPORTANT NOTICES

You can obtain a printed copy of the full versions of the notices below, along with the plan summaries, from Human Resources or by logging in to **Benefitfirst**.

HIPAA PRIVACY AND SECURITY – NOTICE OF PRIVACY PRACTICES

HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices.

HIPAA PORTABILITY – NOTICE OF SPECIAL ENROLLMENT RIGHTS

This notice describes a group health plan's special enrollment rules, including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement of a child for adoption, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.

COBRA – FIRST NOTICE OF COBRA RIGHTS

This notice advises covered employees, covered spouses, and covered dependents of the right to purchase a temporary extension of group health coverage when coverage is lost due to a qualifying event.

PRESCRIPTION DRUG COVERAGE AND MEDICARE

Entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals – must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage.

MEDICAL PRE-TAX PREMIUMS PLAN

Enrollment in a pre-tax premium plan authorizes premiums for group health plan benefits to be payroll-deducted on a pre-tax basis.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT NOTICE (CHIPRA)

This annual notice notifies employees of potential state opportunities for premium assistance to help pay for employer-sponsored health coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

Participants and beneficiaries of group health plans who are receiving mastectomy-related benefits can choose to have breast reconstruction following a mastectomy.

HEALTH CARE REFORM NOTICE: NOTICE OF EXCHANGE/ MARKETPLACE

The employer must provide all employees with an Exchange Notice that includes a description of services provided by the Exchange. The notice must also explain the premium tax credit available if a qualified health plan is purchased through the Exchange. The employee must also be informed that if a health plan through the Exchange is elected, they may lose the employer contribution to any benefit plans offered by the employer.

WELLNESS PROGRAM DISCLOSURE

If it is unreasonably difficult due to a medical condition for you to achieve the standard for reward or if it is medically inadvisable for you to attempt to achieve the standard for reward under your employer's wellness program, please contact your employer's Human Resources representative to develop another way for you to qualify for the wellness program reward.

YOUR RIGHTS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance, and/or deductible.

Full notices are following this page.

Health Plan Compliance Notices

Disclaimer: This document contains many of the required Health and Welfare Plan model notice templates provided by the Department of Labor and other Federal agencies. Most employers prefer to include required notices in their open enrollment materials for ease of distribution.

Some of these notices may require distribution outside of the open enrollment period or to both employees as well as dependent participants. For example, the General COBRA Notice must be provided to not only participating employees but also to participating spouses.

In addition, some notices may require further customization, based on the specific terms of your plan. For example, if you offer a fully-insured plan and any state-mandated billing requirements apply to your plan, a state summary or state-developed model language may need to be added to your Surprise Medical Bills Notice.

Employers may also be subject to additional State laws and Federal disclosures not outlined in these materials. For example, the ACA requires that employers distribute a Marketplace Notice to all employees within 14 days of the employee's start date; because this notice is required to be distributed to all employees upon hire and not on an annual basis and must be highly customized, this notice is not included in this packet. Similarly, if you offer a wellness program that asks participants health-related questions (e.g., a health risk assessment) or involves a medical examination (e.g., biometric testing), then an additional ADA Notice will be required that contains customized information relating to your specific wellness plan. For a more detailed overview of commonly required health plan compliance notices, ask your McGriff Account Team for our annual Employee Benefit Plan Reporting and Disclosure Guide.

If you have questions about or need additional clarity on the notices provided herein, please reach out to your McGriff Account Team.

Medicare Part D Creditable Coverage Notice

Important Notice from City of New Port Richey
About your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered by the PPO 1500, PPO 3500 & QHDHP 5000 through City of New Port Richey 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. **City of New Port Richey has determined that the prescription drug coverage offered by the PPO 1500, PPO 3500 & QHDHP 5000 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 through 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 coverage through City of New Port Richey will not be affected. You can keep this coverage if you elect Part D, and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current group health coverage through City of New Port Richey, be aware that you and your dependents will be able to get this coverage back. Reentry into the plan is subject to the underlying terms of the Plan.

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 group health coverage through City of New Port Richey 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 nineteen 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 the Plan Administrator listed below for further information. **NOTE:** You'll get this notice each year or if the creditable coverage status of this plan through City of New Port Richey changes. You 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
- 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).

For purposes of this notice, the Plan Administrator is:

Blue Cross and Blue Shield of FL Inc
727-853-1016

WHCRA Enrollment/Annual Notice

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 727-853-1016 for more information.

For purposes of this notice, the plan administrator is:

Blue Cross and Blue Shield of FL Inc
727-853-1016

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

****Continuation Coverage Rights Under COBRA****

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 does not accept late enrollees.

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."

If the Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to City of New Port Richey 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 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;
- If the Plan provides retiree health coverage, 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 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 in writing within 60 days. You must provide this written notice to Blue Cross and Blue Shield of FL Inc at 5919 Main Street, New Porty Richey, FL 34652.

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 the Social Security Administration (SSA) to be disabled and you timely notify the Plan Administrator **in writing**, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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.

In order for this disability extension to apply, you must timely notify the Plan Administrator **in writing** of the SSA disability determination before the end of the 18-month period of continuation coverage and within 60 days after the later of (i) the date of the initial qualifying event; (ii) the date on which coverage would be lost because of the initial qualifying event; or (iii) the date of the SSA disability determination. **This notice must be mailed to Blue Cross and Blue Shield of FL Inc at 5919 Main Street, New Porty Richey, FL 34652**. Oral notice, including notice by telephone, is not acceptable. The written notice must include the name and address of the employee covered under the plan; the name of the disabled qualified beneficiary; the date that the qualified beneficiary became disabled; and the date that the SSA made its determination of disability. Your notice must also include a copy of the SSA disability determination. If these procedures are not followed or if written notice is not provided to the Plan Administrator within the required time period, there will be no disability extension of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of any revocation of Social Security disability benefits.

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, Children's Health Insurance Program (CHIP), 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**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

(see https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/cobra/model-general-notice.docx).

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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 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 (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). 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

PPO 1500, PPO 3500 & QHDHP 5000
City of New Port Richey
5919 Main Street, New Porty Richey, FL 34652
727-853-1016

Special Enrollment Notice

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 and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward 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 a 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.

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator listed below:

Blue Cross and Blue Shield of FL Inc
727-853-1016

Your Rights and Protections Against Surprise Medical Bills

When youget emergencycare orare treatedby an out-of-networkproviderat an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments,coinsurance and/ordeductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up yourprotections from balancebilling.You also aren't required to getout-of-network care.You canchooseа providerorfacility in your plan'snetwork.

When balance billing isn't allowed, you also have these protections:

- You're only responsible forpaying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilitiesdirectly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for servicesin advance (also known as "priorauthorization").
    - Cover emergencyservices by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it wouldpay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergencyservices or out-of-network services toward your in-network deductible andout-of-pocketlimit.

If you think you've been wrongly billed, contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1.800.985.3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

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The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefits information. While every effort was taken to report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Summary, contact Human Resources.

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