2016 Retiree Benefits Guide

Plan Year Effective January 1, 2016

Open Enrollment
October 12, 2015 –
November 2, 2015

Retiree Benefit Highlights

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Introduction

The Town of Palm Beach offers medical and dental insurance benefits to all retirees and pension plan participants. You are receiving this guide because you are currently enrolled in one or more of the insurance plans offered by the Town. The pre-enrollment confirmation letter you received with this guide identifies the plans you are currently enrolled.

The Retiree Benefit Guide provides a general summary of the benefit options as a reference. Please refer to the Town's applicable Certificate of Coverage books for a detailed description of all available benefit programs. Certificate of Coverage books are available upon request from the Human Resources Department.

ONLINE BENEFITS ENROLLMENT

Beginning **October 12, 2015**, you may access the Benefits Enrollment System to make changes to your plan elections. To access the system:

- Go to http://eden.townofpalmbeach.com
- Sign in by using your previously created username and password OR click on Register Now! to set up a username and password.

This easy-to-use system is available 24 hours a day, 7 days a week, and can be accessed from any computer with Internet access. To set up a username and password or if you cannot remember your username and/or password, follow the instructions included in your open enrollment packet.

REMINDER: The open enrollment period begins October 12, 2015 through Midnight, November 2, 2015

HUMAN RESOURCES DEPARTMENT

Contact the Human Resources Department for assistance with understanding your benefit plans. Office hours are Monday through Friday from 8:30 AM to 5:00 PM. Please call Human Resources to make changes to your personal information, dependent information, or to obtain assistance in making plan election changes.

Human Resources Department: (561) 838-5450, Option 2

REMINDER:

REVIEW AND UPDATE BENEFICIARY INFORMATION

PRESCRIPTION DRUG COVERAGE

The Town's pharmacy provider is CVS/Caremark administered through RxBenefits, Inc. Note that although your coverage is through CVS/Caremark, you are not just limited to CVS pharmacies. CVS/Caremark is a pharmacy company that is focused on helping people on their path to better health. They maintain a national network of nearly 60,000 retail pharmacies, including their CVS/pharmacy stores. CVS/Caremark's goal is to help you and your family manage your drug costs and maximize your pharmacy benefits. For more information on CVS/Caremark, visit www.caremark.com

Group Insurance Eligibility

ELIGIBILITY

To be eligible for the Town's insurance coverage, a retired Town employee must begin to receive Town retirement benefits immediately following termination of Town employment; or if the employee leaves Town employment prior to the normal retirement date, he/she must have at least 10 years of service with the Town, and reach the normal retirement date under the Town Retirement Plan or the age at which a distribution from the defined contribution plan is allowed in accordance with section 72(t)(2)(A) of the Internal Revenue Code. In any event, an eligible employee or former employee must elect the Town's insurance coverage at the time of retirement from the Town or at the time he/she begins to receive retirement benefits.

Employees who leave Town employment prior to the normal retirement date must notify the Human Resources Department no later than 30 days after beginning to receive retirement benefits from any Town retirement plan, and must elect Town insurance coverage at that time to be eligible for coverage. Retirees who do not elect Town insurance coverage by the time they begin to receive Town retirement benefits are not eligible to enroll in the Town's insurance program during any subsequent open enrollment period.

TERMINATION

You may cancel your coverage with the Town at any time throughout the year. Cancellation notice must be provided in writing to the Human Resources Department. It is important to note that should you elect to cancel your coverage, you will not be permitted to re-enroll in the Town's insurance plans at any time in the future. Coverage will terminate on the last day of the month in which notice was provided.

DISABLED DEPENDENTS

- Coverage for an unmarried dependent child may be continued beyond age 26, if:
- The dependent is otherwise eligible for coverage under the group plan; AND
- The dependent is physically or mentally disabled and incapable of self-sustaining employment by reason of mental retardation or physical handicap; AND
- Symptoms or causes of the child's handicap existed prior to the child's 26th birthday.

Proof of disability will be required upon request. Please contact the Human Resources Department for more information.

DEPENDENT ELIGIBILITY

A dependent is defined as the legal spouse, registered domestic partner and/or dependent child(ren) of the participant. Dependent children may be covered under the medical plan until the end of the year in which they turn 26. Coverage for dependent children on the dental plan will end on the child's 26th. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A foster child
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse
- The newborn child of a covered dependent child who has not yet reached age 26. Coverage will automatically terminate 18 months after the birth of the newborn child.

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Group Insurance Eligibility continued

MEDICAL COVERAGE MAY CONTINUE PAST THE AGES OF 26 TO AGE 30, IF:

- The child is unmarried with no dependents; AND
- The child is a Florida resident OR a full-time or part-time student; AND
- The child is not enrolled in any other health coverage policy or plan, AND
- The child is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefit plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If your child(ren) meets the criteria above and you would like to cover him/her under the Town's health plan, please contact the Human Resources Department for more information.

Note: This extension of coverage applies only to medical insurance. All other coverages will end on the dependent's 26th birthday.

MEDICARE COVERAGE AND DISCOUNTED PREMIUMS

Retirees and/or a covered spouse enrolled in Medicare Part A and Part B coverage, may qualify for a reduced premium if they are a participant of the PPO or POS plans.

If you are enrolled with Medicare Part A and Part B, **please send a copy of your Medicare card to the Human Resources Dept.** The reduced health insurance premium will take effect the first of the month following receipt of the Medicare card. For more information, please contact the Human Resources Dept.

IMPORTANT INFORMATION ABOUT MEDICARE

Please note that Florida Blue will process medical claims for all retirees and dependents who are 65 or over AND eligible to enroll with Medicare, as if Medicare Part A and Part B have been elected. If you are 65 or over AND have NOT enrolled with Medicare Part A and B, you may be responsible for paying some or all of the medical claims.

In order to avoid this increase in out-of-pocket costs and obtain the discounted premium, please provide the Town of Palm Beach with a copy of your Medicare Card that includes Part A and Part B coverage. Medicare Part A covers inpatient hospital stays and Part B covers physician and outpatient services.

If you are 65 and **have not** applied for either of both Part A and Part B Medicare coverage, please contact the local Social Security Office by calling (800) 772-1213 to arrange an appointment in order to enroll with these benefits. You may also request the paperwork be sent to your home where you would complete the required forms then return them to Social Security.

Health Insurance: Blue Care Open Access HMO Plan

The Town offers an Open Access HMO plan through Florida Blue. The retire sliding scale containing the premium rates for plan year 2016, a brief plan description and summary of the plan's schedule of benefits are provided on the following pages. For detailed coverage information, refer to the Plan Documents available upon request from the Human Resources Department.

OPEN ACCESS HMO PLAN

The BlueCare HMO plan is an "Open Access" plan. This means you have the freedom to see any physician or health care professional from the Florida Blue Network, including specialists, **without a referral**. In addition, you do not have to worry about any claim forms or bills. With the HMO plan, you are protected from balance billing, which means the provider cannot charge you the difference above Florida Blue's allowable amount. You simply pay the copay at the time of service.

OUT-OF-NETWORK SERVICES FOR EMERGENCY SERVICES

Although the open access HMO plan does not cover out-of-network services, exceptions are made for emergency situations. Should you or a covered dependent be hurt while you are away from home, emergency room visits, regardless of location, are treated as in-network. This means that the same copays you pay at home, will be applicable when you are away from home.

AWAY FROM HOME CARE

Away From Home Care (AFHC) is a program provided to members and covered dependents temporarily residing outside of the Florida Blue HMO network. Consider the AFCH program if:

- Your child is a student and is away at school outside of the Florida Blue Network.
- You have a covered dependent living in another state.
- You are planning long-term travel to another state.

For more information or to request AFHC, please call Florida Blue Customer Service at (800) 352-2583.

OUT-OF-POCKET LIMIT

The maximum out-of-pocket limit is the maximum amount you will pay during a coverage period. Once the limit has been met, the plan will provide 100% coverage thereafter for that member. Out-of-pocket limits do not include premiums, balance-billed charges, and health care this plan doesn't offer. The maximum annual out-of-pocket for an individual on the HMO plan is $1,500 and $3,000 per family.

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HMO – Retiree Sliding Scale Insurance Premium Rates – 2016

Years of Service		Q1		Q2		Q3		Q4	
		50%		52%		56%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
25+ years	Retiree	$396.09		$411.93		$443.62		$491.33	
	Retiree +1 Dependent	$836.50		$869.95		$936.87		$1,042.29	
	Retiree +2 Dependents	$1,049.55		$1,091.53		$1,175.49		$1,447.16	
	Retiree +3 Dependents	$1,262.59		$1,313.09		$1,414,10		$1,852.02	
		52%		56%		58%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
20-24 years	Retiree	$411.93		$443.62		$459.46		$491.33	
	Retiree +1 Dependent	$869.95		$936.87		$970.33		$1,042.29	
	Retiree +2 Dependents	$1,091.53		$1,175.49		$1,217.47		$1,447.16	
	Retiree +3 Dependents	$1,313.09		$1,414.10		$1,464.60		$1,852.02	
		56%		58%		60%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
15-19 years	Retiree	$443.62		$459.46		$475.30		$491.33	
	Retiree +1 Dependent	$936.87		$970.33		$1,003.79		$1,042.29	
	Retiree +2 Dependents	$1,175.49		$1,217.47		$1,259.45		$1,447.16	
	Retiree +3 Dependents	$1,414.10		$1,464.60		$1,515.10		$1,852.02	
		Maximum		Maximum		Maximum		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
10-14 years	Retiree	$491.33		$491.33		$491.33		$491.33	
	Retiree +1 Dependent	$1,042.29		$1,042.29		$1,042.29		$1,042.29	
	Retiree +2 Dependents	$1,447.16		$1,447.16		$1,447.16		$1,447.16	
	Retiree +3 Dependents	$1,852.02		$1,852.02		$1,852.02		$1,852.02	

Monthly Pension Earnings		
Quartile	Minimum	Maximum
Q1	-	$1,620.00
Q2	$1,620.01	$2,973.22
Q3	$2,973.23	$4,601.32
Q4	$4,601.33 or greater	

*Rates are based on the commingled experience of the retiree group with the claims experience of the active employees in accordance with F.S. 112.0801

Health Insurance: BlueChoice PPO and BlueOptions POS Plans

The Town of Palm Beach will continue to offer health plans through Florida Blue. The retiree sliding scale containing the premium rates for plan year 2015, a brief plan description and summary of the plan's schedule of benefits are provided on the following pages. For detailed coverage information, please refer to the Plan Documents available upon request from the Human Resources Department.

PPO AND POS PLANS

The BlueChoice PPO and BlueOptions POS plans offer the convenience of referral-free access to doctors. A primary care physician is not required. The plans also provide benefits for services received from out-of-network providers (providers that do not participate in the Florida Blue PPO and POS network). Once you satisfy your deductible, you are responsible for a percentage of the charges (or coinsurance) based on Florida Blue's discounted fee or "allowable amount." In addition to your coinsurance, out-of-network providers may also bill you for the difference above Florida Blue's allowable amount and the out-of-network provider's own fee for any particular service. This is called "balance billing." In order to maximize your savings, choose a provider in the Florida Blue network.

CALENDAR YEAR DEDUCTIBLE

The calendar year deductible applies when using providers in or out of the network. Please see the benefit grids for details for Individual and Family coverage inside and outside of the network area.

OUT-OF-POCKET LIMIT

The maximum out-of-pocket limit is the maximum amount you will pay during a calendar year coverage period. Once the limit has been met, the plan will provide 100% coverage thereafter for that member. Out-of-pocket limits do not include premiums, balanced-billed charges, and health care this plan doesn't cover. The maximum annual out-of-pocket for an individual on the PPO and POS plans are different in-network than out-of-network. Please see the Schedule of Benefits for details.

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PPO – Retiree Sliding Scale Insurance Premium Rates – 2016

Years of Service		Q1		Q2		Q3		Q4	
		50%		52%		56%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
25+ years	Retiree	$460.06	$227.00	$478.46	$236.08	$515.26	$254.24	$591.23	$291.72
	Retiree +1 Dependent	$970.72	$480.52	$1,009.54	$499.74	$1,087.20	$538.18	$1,253.07	$620.29
	Retiree +2 Dependents	$1,236.03		$1,285.47		$1,384.35		$1,757.27	
	Retiree +3 Dependents	$1,501.35		$1,561.40		$1,681.51		$2,261.47	
		52%		56%		58%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
20-24 years	Retiree	$478.46	$236.08	$515.26	$254.24	$533.66	$263.32	$591.23	$291.72
	Retiree +1 Dependent	$1,009.54	$499.74	$1,087.20	$538.18	$1,126.03	$557.40	$1,253.07	$620.29
	Retiree +2 Dependents	$1,285.47		$1,384.35		$1,433.79		$1,757.27	
	Retiree +3 Dependents								
		56%		58%		60%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
15-19 years	Retiree	$515.26	$254.24	$533.66	$263.32	$552.07	$272.40	$591.23	$291.72
	Retiree +1 Dependent	$1,087.20	$538.18	$1,126.03	$557.40	$1,164.86	$576.62	$1,253.07	$620.29
	Retiree +2 Dependents	$1,384.35		$1,433.79		$1,483.23		$1,757.27	
	Retiree +3 Dependents	$1,681.51		$1,741.56		$1,801.61		$2,261.47	
		Maximum		Maximum		Maximum		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
10-14 years	Retiree	$591.23	$291.72	$591.23	$291.72	$591.23	$291.72	$591.23	$291.72
	Retiree +1 Dependent	$1,253.07	$620.29	$1,253.07	$620.29	$1,253.07	$620.29	$1,253.07	$620.29
	Retiree +2 Dependents	$1,757.27		$1,757.27		$1,757.27		$1,757.27	
	Retiree +3 Dependents	$2,261.47		$2,261.47		$2,261.47		$2,261.47	

Monthly Pension Earnings		
Quartile	Minimum	Maximum
Q1	-	$1,620.00
Q2	$1,620.01	$2,973.22
Q3	$2,973.23	$4,601.32
Q4	$4,601.33 or greater	

*Rates are based on the commingled experience of the retiree group with the claims experience of the active employees in accordance with F.S. 112.0801

POS – Retiree Sliding Scale Insurance Premium Rates – 2016

Years of Service		Q1		Q2		Q3		Q4	
		50%		52%		56%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
25+ years	Retiree	$398.98	$194.98	$414.94	$202.78	$446.86	$218.38	$505.53	$247.05
	Retiree +1 Dependent	$840.97	$412.50	$874.60	$429.00	$941.88	$462.00	$1,069.07	$524.39
	Retiree +2 Dependents	$1,063.21		$1,105.73		$1,190.79		$1,491.41	
	Retiree +3 Dependents	$1,285.45		$1,336.87		$1,439.70		$1,913.75	
		52%		56%		58%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
20-24 years	Retiree	$414.94	$202.78	$446.86	$218.38	$462.82	$226.18	$505.53	$247.05
	Retiree +1 Dependent	$874.60	$429.00	$941.88	$462.00	$975.52	$478.50	$1,069.07	$524.39
	Retiree +2 Dependents	$1,105.73		$1,109.79		$1,233.32		$1,491.41	
	Retiree +3 Dependents	$1,336.87		$1,439.70		$1,491.12		$1,913.75	
		56%		58%		60%		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
15-19 years	Retiree	$446.86	$218.38	$462.82	$226.18	$478.78	$233.98	$505.53	$247.05
	Retiree +1 Dependent	$941.88	$462.00	$975.52	$478.50	$1,009.16	$495.00	$1,069.07	$524.39
	Retiree +2 Dependents	$1,190.79		$1,233.32		$1,275.85		$1,491.41	
	Retiree +3 Dependents								
		Maximum		Maximum		Maximum		Maximum	
		Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
10-14 years	Retiree	$505.53	$247.05	$505.53	$247.05	$505.53	$247.05	$505.53	$247.05
	Retiree +1 Dependent	$1,069.07	$524.39	$1,069.07	$524.39	$1,069.07	$524.39	$1,069.07	$524.39
	Retiree +2 Dependents	$1,491.41		$1,491.41		$1,491.41		$1,491.41	
	Retiree +3 Dependents	$1,913.75		$1,913.75		$1,913.75		$1,913.75	

Monthly Pension Earnings		
Quartile	Minimum	Maximum
Q1	-	$1,620.00
Q2	$1,620.01	$2,973.22
Q3	$2,973.23	$4,601.32
Q4	$4,601.33 or greater	

*Rates are based on the commingled experience of the retiree group with the claims experience of the active employees in accordance with F.S. 112.0801

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Florida Blue Health Insurance Summaries – 2016 Plan Year

	BlueCare (HMO)	BlueChoice (PPO)	BlueOptions (POS)
COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted)			
Deductible (Per Person/Family Aggregate)			
In-Network	N/A	$500 / $1,500	$1,000 / $2,000
Out-of-Network	N/A	$1,000 / $3,000	$2,000 / $4,000
Coinsurance (Member Responsibility)			
In-Network	N/A	10%	20%
Out-of-Network	N/A	30%	50%
Out-of-Pocket Maximum (Per Person/Family Aggregate)	Includes all co-pays	Includes deductible, co-insurance, and co-pays	Includes deductible, co-insurance, and co-pays
In-Network	$1,500 / $3,000	$1,500 / $4,500	$2,000 / $4,000
Out-of-Network	N/A	$3,000 / $9,000	$4,000 / $6,000
Lifetime Maximum	No maximum	No maximum	No maximum
PROFESSIONAL PROVIDER SERVICES			
Office Services			
In-Network Family Physician	$20	$25	$35
Out-of-Network Family Physician	N/A	Deductible + 30%	Deductible + 50%
In-Network Specialist	$40	$40	Deductible + 20%
Out-of-Network Specialist	N/A	Deductible + 30%	Deductible + 50%
Maternity - Prenatal / Postnatal Care			
In-Network Specialist	$40	$40	Deductible + 20%
Out-of-Network Specialist	N/A	Deductible + 30%	Deductible + 50%
Maternity - Delivery and All Services			
In-Network Specialist	$0	Deductible + 10%	Deductible + 20%
Out-of-Network Specialist	N/A	Deductible + 10%	In-Network Deductible + 20%
In-Network Hospital	$500	Deductible + 10%	Deductible + 20%
Out-of-Network Hospital	N/A	$300 PAD + Deductible + 30%	$500 PAD + Deductible + 50%
Allergy Injections			
In-Network Family Physician	$5	$5	$5
Out-of-Network Family Physician	N/A	Deductible + 30%	Deductible + 50%
In-Network Specialist	$5	$5	Deductible + 20%
Out-of-Network Specialist	N/A	Deductible + 30%	Deductible + 50%
Provider Services at Hospital and ER			
In-Network Family Physician	$0	Deductible + 10%	Deductible + 20%
Out-of-Network Family Physician	Hospital: N/A ER: $0	Deductible +10%	In-Network Deductible + 20%
In-Network Specialist	$0	Deductible + 10%	Deductible + 20%
Out-of-Network Specialist	Hospital: N/A ER: $0	Deductible +10%	In-Network Deductible + 20%

Florida Blue Health Insurance Summaries – 2016 Plan Year (continued)

	BlueCare (HMO)	BlueChoice (PPO)	BlueOptions (POS)
Provider Services at Other Locations			
In-Network Family Physician	$0	Deductible + 10%	Deductible + 20%
Out-of-Network Family Physician	N/A	Deductible + 30%	Deductible + 20%
In-Network Specialist	$0	Deductible + 10%	Deductible + 20%
Out-of-Network Specialist	N/A	Deductible + 30%	Deductible + 20%
Radiology, Pathology, and Anesthesiology Provider Services at Ambulatory Surgical Center at Hospital			
In-Network Specialist	ASC: $0 Hospital: $0	Deductible + 10%	In-Network Deductible + 20%
Out-of-Network Specialist	N/A	Deductible + 30%	In-Network Deductible + 20%
PREVENTIVE CARE			
Adult Wellness Office Services			
In-Network Family Physician	$0	$0	$0
Out-of-Network Family Physician	N/A	30% (No deductible)	50%
In-Network Specialist	$0	$0	$0
Out-of-Network Specialist	N/A	30% (No deductible)	50%
Colonoscopies (Routine) Age 50+ then Frequency Schedule applies			
In-Network	$0	$0	$0
Out-of-Network	N/A	30% (No deductible)	50%
Mammograms (Routine and Dx)			
In-Network	$0	$0	$0
Out-of-Network	N/A	30%	50%
Well Child Office Visits (No BPM)			
In-Network Family Physician	$0	$0	$0
Out-of-Network Family Physician	N/A	30% (No deductible)	50%
In-Network Specialist	$0	$0	$0
Out-of-Network Specialist	N/A	30% (No deductible)	50%
EMERGENCY/URGENT/CONVENIENT CARE			
Ambulance Maximum (combined ground, air, and water - per day)			
In-Network	$0	Deductible + 10%	Deductible + 20%
Out-of-Network	$0 - only for emergencies	Deductible + 10%	In-Network Deductible + 20%
Convenient Care Centers (CCC)			
In-Network	$20	$25	
Out-of-Network	N/A	Deductible + 30%	
Emergency Room Facility Services Co-payment waived if admitted (see Emergency Room to Inpatient for co-pay and co-insurance) (also see Professional Provider Services)			
In-Network	$115	Deductible + 10%	$250
Out-of-Network	$115	Deductible + 10%	$250
Emergency Room to Inpatient			
In-Network	$500	Deductible + 10%	Deductible + 20%
Out-of-Network	$500	Deductible + 10%	Deductible + 20%
Urgent Care Centers (UCC)			
In-Network	$30	$30	$50
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%

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Florida Blue Health Insurance Summaries – 2016 Plan Year (continued)

	BlueCare (HMO)	BlueChoice (PPO)	BlueOptions (POS)
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services			
Ambulatory Surgical Center (ASC)			
In-Network	$100	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%
Independent Clinical Lab			
In-Network	$0	10%	$0
Out-of-Network	N/A	30%	Deductible + 50%
Independent Diagnostic Testing Facility - X-rays and AIS (includes Physician Services)			
In-Network - Advanced Imaging Services (AIS)	$0	10%	20%
Out-of-Network - Advanced Imaging Services (AIS)	N/A	Deductible + 30%	Deductible + 50%
In-Network - Other Diagnostic Services	$0	10%	20%
Out-of-Network - Other Diagnostic Services	N/A	Deductible + 30%	Deductible + 50%
Inpatient Hospital (per admit)			
In-Network	$500	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	$300 PAD + Deductible + 30%	$500 PAD + Deductible + 50%
Outpatient Hospital (per visit)			
In-Network	Surgical: $100 Non-Surgical: $100	Deductible + 10%	$250
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Hospitalization			
In-Network	$500	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	$300 PAD + Deductible + 30%	$500 PAD + Deductible + 50%
Outpatient Hospitalization (per visit)			
In-Network	$100	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%
Provider Services at Hospital and ER			
In-Network Family Physician or Specialist	$0	Deductible + 10%	Deductible + 20%
Out-of-Network Provider	Hospital: N/A ER: $0	Deductible + 10%	Deductible + 50%
Emergency Room Facility (per visit)			
In-Network	$115	Deductible + 10%	$250
Out-of-Network	$115	Deductible + 10%	$250
OTHER SPECIAL SERVICES AND LOCATIONS			
Chiropractic Care	30 visits	60 visits	35 visits
Durable Medical Equipment, Prosthetics, Orthotics BPM	All other: No maximum	All other: No maximum	All other: No maximum
In-Network	Motorized Wheelchair: $500 All Other: $0	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%

Florida Blue Health Insurance Summaries – 2016 Plan Year (continued)

	BlueCare (HMO)	BlueChoice (PPO)	BlueOptions (POS)
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services			
Ambulatory Surgical Center (ASC)			
In-Network	$100	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%
Independent Clinical Lab			
In-Network	$0	10%	$0
Out-of-Network	N/A	30%	Deductible + 50%
Independent Diagnostic Testing Facility - X-rays and AIS (includes Physician Services)			
Home Health Care BPM	No maximum	50 visits	20 visits Per Benefit Period Max
In-Network	$0	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%
Hospice LTM	No maximum	No maximum	No maximum
In-Network	$0	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%
Outpatient Therapy and Spinal Manipulations BPM	30 visits/30 manipulations	60 visits (includes up to 26 spinal manipulations)	35 visits
Outpatient Rehab Center			
In-Network	$5	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%
In-Network Physician Office	$40	$40	Deductible + 20%
Out-of-Network Physician Office	N/A	Deductible + 30%	Deductible + 50%
Skilled Nursing Facility BPM	90 days	60 days	60 days Per Benefit Period Max
In-Network	$0	Deductible + 10%	Deductible + 20%
Out-of-Network	N/A	Deductible + 30%	Deductible + 50%

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Florida Blue Perks

Staying healthy just got less expensive

GREAT DISCOUNTS AND VALUABLE INFORMATION THAT CAN BE USED ALL YEAR LONG—BLUE365®

You can save BIG on a wide variety of healthy products and services through our members-only discount program—Blue365 [1]. Take advantage of exclusive discounts at select local companies and leading, national brands for everyday health and wellness or family care. Save up to 60% on fitness clubs, exercise equipment, contact lenses or glasses, nutrition and weight management programs and so much more! All available to you as part of your Florida Blue membership. We're dedicated to your pursuit of health.

Personal Care

LASIK

You will have a choice of companies to go to for great discounts on laser vision correction services for traditional and custom LASIK. Check out QualSight® and LasikPlus for all of their options.

DAVIS VISION

Davis Vision's national network of vision professionals offers 10-40% off everything from exams to lenses, frames, contacts and more.

HEARING CARE AND PRODUCTS

You will have a choice of companies for your hearing needs. TruHearing and BeltoneTM offer big discounts on eligible products and services, including hearing and screening exams, hearing aids, plus custom fitting and follow-up visits.

CARINGBRIDGE

Members will have free access to a nonprofit online community where people experiencing significant health challenges can connect with family and friends.

HOPE PAIGE DESIGNS

Members will have access to Hope Paige Designs' discounted products through the Blue365 website. Hope Paige Designs offers a line of fashionable, trendy and chic medical emergency bracelets. Every member who makes a purchase from Hope Paige Designs' online store will receive a 30% discount off list price and free shipping on the entire order.

ELDERCARE

Through SeniorlinkTM, an eldercare management and advisory service, you'll receive discounts on 3- or 12-month memberships that include unlimited personalized telephone and Internet-based assistance, advice and support when caring for a family member. They can help you understand your options, create a comprehensive plan of care that promotes independence and quality of life for seniors, and help you find the perfect local eldercare services in your community or across the country.

Wellness

It's easy to find out all the details for these exclusive savings—the information is available online 24/7 for your convenience.

Simply log in at floridablue.com. New discounted products and services are being added all the time—so check back often or new savings opportunities.

FloridaBlue.com is at your service

Wherever you go, whenever you need it, you have access to your Florida Blue personal health care information.

As a member, you can log in anytime and find everything you need to know about your health plan, plus free tools and resources.

If you haven't already registered—it's easy!

Just visit FloridaBlue.com. All you need is your member number (located on your member ID card). You'll have access to all the information you need to take control of your health—right at your fingertips!

FloridaBlue.com gives you personal health information when you need it.

- Review your **plan benefits** and find out where you stand with your deductible.
- **Find a doctor or hospital** in your plan's network and details such as hospital quality ratings, or special programs doctors participate in, the doctor's age and gender, and reviews by patients.
- **Compare and estimate** your costs for office visits, imaging services and surgeries so you know before you go.
- **View claim activity**, status and history.
- Create a **Personal Health Record** so your doctor visits and lab results are all in one secure place.
- **Access your monthly health statement**—which gives you an overview of savings, claims and expenses.
- Print a temporary **ID card** or request a new member ID card.
- Take your **Personal Health Assessment** to get a clear picture of your health status and create action plans that work with your personal needs and lifestyle.
- Use the **Health Assistant** to set personal health goals, choose activities, create plans and track your progress in areas like exercise, nutrition, stress and weight management.
- Research **health topics from A-Z** with the aid of pictures, videos and a variety of tools.
- Get access to health-related **member discounts** such as gym memberships, weight loss programs, vision and hearing care.

Florida Blue mobile. *Need it. Find it. Go.*

FOR EVERYONE — MEMBERS AND NON-MEMBERS.

- Access health information and tools on the go.
- Works on any Smartphone —iPhone®, Android® and even the iPad®.
- Just type in FloridaBlue.com from your mobile browser or download the FREE app for your iPhone or Android!

SAVE TIME.

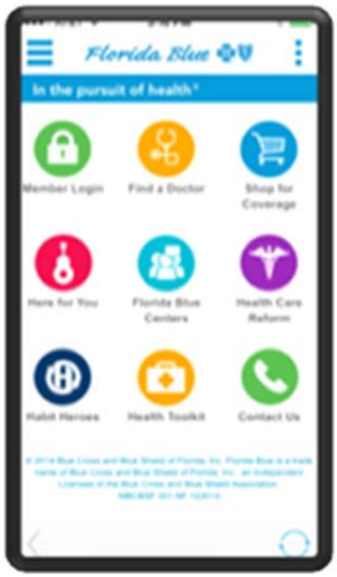
- Get your plan details such as deductibles, HSA balance and claims – on the go
- Get a picture of your Member ID card
- Locate doctors in your plan from wherever you are

SAVE MONEY.

- Get connected to a person who can help you manage your out-of-pocket costs and find quality care
- Shop for affordable health plans and get a quote instantly

STAY HEALTHY.

- Take charge of your health with the health toolkit



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Health Insurance: Prescription Drugs

The Town's pharmacy management is through CVS/Caremark administered through RxBenefits, Inc. Please note that although your coverage is through CVS/Caremark, you are not limited to only CVS pharmacies. There are more than 60,000 pharmacies in the network. As a reminder, there is a $100 deductible for brand name prescription drugs. The deductible will not apply to generic brands. Copay information and a brief plan description is provided below.

Rx Benefits 30 Day Supply	BLUE CARE – OPEN ACCESS HMO	BLUECHOICE PPO	BLUE OPTIONS POS
Generic	$10	$10	$10
Preferred	$30	$30	$35
Non-Preferred	$30 copay + 50% of cost	$30 copay + 50% of cost	$40 copay + 50% of cost
***A $100 Rx Deductible will apply to Brand Drug Prescriptions. The deductible will not apply to generics.**			
90-Day Supply/Mail Order	BLUE CARE – OPEN ACCESS HMO	BLUECHOICE PPO	BLUE OPTIONS POS
Generic	$20	$20	$20
Preferred	$60	$60	$70
Non-Preferred	$60 copay + 50% of cost	$60 copay + 50% of cost	$80 copay + 50% of cost
***A $100 Rx Deductible will apply to Brand Drug Prescriptions. The deductible will not apply to generics.**			

90-DAY SUPPLY AND MAIL ORDER SERVICES

In addition to filling your prescription at a local pharmacy, the plan offers a retail 90-day and a mail order prescription program for maintenance medication for conditions such as asthma, allergies, birth control, diabetes, high blood pressure, and many others. With these services, you can get a 90-day supply of your medication(s) at a lower cost than retail.

Mail order prescriptions are mailed right to your home. There are two options to enroll:

- Call Fast-Start toll-free at (855)383-9422 and let the representative know you wish to fill your prescriptions through mail. Provide the information on your benefit ID card, the names of the long-term medications you take, your doctor's name and phone number, and your mailing address. Caremark will do the rest and get the information from your physician; OR

- Simply have your physician write a new 90-day prescription for each maintenance medication you are taking, complete the mail order form available at www.caremark.com , and mail that prescription(s) and order form in the envelope provided to the Caremark Mail Order Pharmacy.

Please note, new orders take 10-14 business days to process; therefore, you will need to have a 2-week supply of medication on hand when mailing a new order to the Mail Order Pharmacy. For more information on the mail order program, please call Customer Service at (800) 334-8134, or go to www.caremark.com .

CVS/caremark

Health Insurance: Prescription Drugs - continued

PREFERRED MEDICATION LIST

A Preferred Medication List (PML) is a list of medications that have been approved by the plan provider in conjunction with a committee of doctors and pharmacists. All medications on this list are covered by the plan. The pharmacy benefit plan offers three categories— or tiers—of medications that determine your costs (copays):

- **1st Tier Generics:** Generics contain the same active ingredient as their brand-name equivalents and offer the same effectiveness and safety. Some generics use a brand name instead of a chemical name. Both have the lowest copay.
- **2nd Tier Preferred:** Medications in this tier have been selected by your pharmacy benefit plan as preferred-brand medications. They have higher copays than generics but are less costly than non-preferred medications on the third tier.
- **3rd Tier Non-preferred:** Because a generic version or a second-tier alternative is available, non-preferred medications have higher copays and are not listed on the PML.

For a copy of the most up-to-date Preferred Medication List, visit www caremark.com, or contact customer service at 1-(800)-334-8134.

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Dental Insurance: PPO Traditional /Preferred Plan

The Town's dental insurance plan provider is Humana Specialty Benefits (Humana). The employee and Town biweekly contributions are shown below. There are also a brief plan description and summary of the plan's schedule of benefits on the following page. For detailed coverage information, please refer to the Plan Documents available on the Town's Intranet under Employee Benefits Information.

Dental Insurance Premium	HUMANA DENTAL TRADITIONAL PPO PLAN
Bi-Weekly Contributions	**Employee Contribution**
Retiree	$41.74
Retiree + 1 Dependent	$78.31
Retiree + 2 Dependents	$102.13

PPO TRADITIONAL / PREFERRED PLAN

The dental plan offers you the freedom to visit any dentists including those outside the Humana PPO network. Preventative services rendered by in-network providers are covered at 100% without a deductible. Preventative services include oral examinations, x-rays, cleanings, and topical fluoride and sealants for children through the age of 14. Basic services are covered at 80% and major services are covered at 50% (after deductible).

Although services provided by out-of-network providers are covered, the dentist can bill you for charges above the amount covered by the plan. To ensure you do not receive additional charges, visit an in-network dentist.

FINDING A DENTIST AND OTHER ONLINE SERVICES

To find a dentist in your area, visit www.humanadental.com and click on the Find a Provider link at the bottom of the page. For the fastest, most accurate results, enter the ID Number found on your member ID card or create a user ID and password.

By registering, you gain online access to information such as benefit eligibility, claims status, claim history, and more.

CALENDAR YEAR DEDUCTIBLE

The calendar year deductible for the plan is $50 for an individual employee and $150 for family.

ANNUAL MAXIMUM (EXCLUDING ORTHODONTIA SERVICES)

The annual maximum allowable per year is $2,000. Any services provided exceeding the annual maximum amount will be paid by the employee.

CHILD ORTHODONTIA

The lifetime orthodontia maximum is $1,500, for children up to age 19. The plan pays 50% of the covered orthodontia services not to exceed $1,500 per dependent child.

HUMANA.

Dental Insurance: PPO Plan / Traditional Preferred Summary of Benefits

	PPO Plan	
PLAN HIGHLIGHTS	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible (single / family)	$50 / $150	$50 / $150
Preventive Services		
Oral examinations X-rays Cleanings Topical fluoride treatment (through age 14, one per calendar year)* Sealants (through age 14)*	100% No Deductible	90% After Deductible of maximum allowable fee
Basic Services		
Space maintainers (through age 14)* Emergency care for pain relief Basic oral surgery services – basic extractions of erupted tooth or root Fillings (amalgams, composite for anterior teeth) Appliances for children (through age 14) Prefabricated stainless steel crowns Periodontics Endodontics (root canals)	80% After Deductible	60% After Deductible of maximum allowable fee
Major Services		
Crowns Inlays / Onlays Bridgework Dentures Denture relines and rebases Denture repair and adjustments Complex surgical extractions: surgical removal of erupted tooth	50% After Deductible	40% After Deductible of maximum allowable fee
ORTHODONTIA BENEFITS		
Type IV - Orthodontia Benefit Orthodontia Lifetime Maximum Orthodontia Age Limits	50% $1,500 Children to age 19	50% $1,500 Children to age 19

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Annual Notices

HIPAA Special Enrollment Rights Notice

Notice of Privacy Practices- Notice of Town of Palm Beach
Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The effective date of this Notice of **Town of Palm Beach** Health Information Privacy Practices (the "Notice") is January 1, 2016.

The Town of Palm Beach (the "Plan") provides health benefits to eligible employees of the **Town of Palm Beach (**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.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees **[and retirees]** and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, **[retiree]** or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

HIPAA Special Enrollment Notice, page 2

Receipt of Your PHI by the Company and Business Associates **The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.** **Plan Sponsor:** The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

> **Example:** The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

> **Example:** If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

> **Example:** The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

> **Example:** The Plan will receive bills from physicians for medical care provided to you that will contain your PHI.

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HIPAA Special Enrollment Notice, page 3

The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogate ion,
  and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of Services the Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs
- The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.

HIPAA Special Enrollment Notice, page 4

Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan

- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws and creating de-identified health information or a limited data set
- The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

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Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law. Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.
You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

<u>Your Rights With Respect to Your PHI</u>

Confidential Communication by Alternative Means:

If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is

the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example).

The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, pay-ment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2016 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009. The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information

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on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

The Plan has designated **Kennie Wells** as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: **360 South County Road, Palm Beach, FL 33480 or (561) 838-5450.**

Women's Health and Cancer Rights Act Notice

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy

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 consultation between the attending physician and the patient. 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 Blue Cross at the number listed on the back of your ID card.

Health Contingent Wellness Program Notice

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Genetic Information Nondiscrimination Act 2008

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. Our Plan complies with these requirements.

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 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 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.

Effective April 1, 2009, special enrollment rights also exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have 60 days to request special enrollment in the group health plan coverage.

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Special Enrollment Notice continued

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.) To request special enrollment or obtain more information, contact your HR Department.

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

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 one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-956

FLORIDA – Medicaid	KANSAS – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 / Phone: 573-751-2005
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282

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SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

Important Notice from the Town of Palm Beach 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 with the Town of Palm Beach 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. The Town of Palm Beach has determined that the prescription drug coverage offered by the Town of Palm Beach Health 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 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 do decide to enroll in a Medicare prescription drug plan and drop your **Town of Palm Beach** prescription drug coverage, be aware that you and your dependents **may not** be able to get this coverage back.

Please contact your Plan Administrator for more information about what happens to your coverage if you enroll in a Medicare prescription drug 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 coverage with **the Town of Palm Beach** 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 Your Current Prescription Drug Coverage…
Contact Kennie Wells of the Town of Palm Beach at 561-838-5450. For a further explanation of the prescription drug coverage plan provisions/options under the T**own of Palm Beach Health Plan** please consult the relevant plan document provisions.

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For More Information About This Notice…
The Town of Palm Beach has engaged the services of Part D Advisors, Inc. to provide you with further information about this notice. Part D Advisors, Inc. can be reached, toll free, at (888) 447-2783. NOTE: You will receive this notice each year. You will also get it before the next period you can enroll in a Medicare prescription drug coverage, and if this coverage through the Town of Palm Beach 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
- 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).

Date:	October 1, 2015
Name of Entity/Sender:	**Town of Palm Beach**
Contact--Position/Office:	Customer Service, Part D Advisors, Inc.
Address:	17199 N. Laurel Park Drive, Suite 400, Livonia, MI 48152
Phone Number:	(888) 447-2783

Important Contact Information

Health Insurance	Prescription Drug
Florida Blue Customer Service: (800) 352-2583 Website: www.FloridaBlue.com Group No. 30758	Rx Benefits Customer Service (800) 334-8134 Website: www.caremark.com Group No. RX2169 RxBin No. 004436 RxPCN No. ADV
Dental Insurance	**Vision Insurance**
Humana Dental Customer Service: (800) 233-4013 Website: www.humanadental.com Group No. 567286	National Vision Administrators (NVA) Customer Service: (800) 672-7723 Website: www.e-nva.com Group No. 51193
Supplemental Life Insurance	**Flexible Spending Accounts**
Minnesota Life Customer Service: (800) 392-7295 Website: www.minnesotalife.com Group No. 34174	Next Generation Enrollment Customer Service: (888) 266-1732 Website: www.nextgenerationenrollment.com

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Town of Palm Beach 2016 Retiree Benefit Highlights

About This Guide

This guide describes the benefit plans available to you as an employee of the Town of Palm Beach, and its participating subsidiaries. The details of these plans are contained in the official plan documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in your Summary Plan Description (SPD) (as described by the Employee Retirement Income Security Act). If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the Plan documents, the formal wording in the Plan documents will govern. The Town of Palm Beach reserves the right to modify, amend, suspend, or terminate the plan, in whole or in part, at any time, as allowed by law. This guide does not constitute a contract and participation in any of the benefit plans does not guarantee employment.