FINANCE & ADMINISTRATIVE SERVICES
Risk Management Division

CITY OF SUNRISE

Phone: (954) 572-2496
Fax: (954) 572-2382

September 30, 2016

Dear Retiree:

Open enrollment for medical and vision will be October 17, 2016 through October 28, 2016. If you wish to make changes to your coverage you must do so during this open enrollment period. AvMed will remain the administrator of the City's Health Plan and Humana will remain for the City's Vision Plan.

If you do not wish to make any changes for 2017 - NO ACTION IS NECESSARY.

Retirees may terminate coverage at any time. However, once terminated it may not be obtained in the future.

If you would like to make changes, please complete the attached enrollment/change form and pension deduction authorization, return both to Risk Management by October 28, 2016. Changes will be effective January 1, 2017.

Important: If adding dependents — you must provide proof of a legal relationship/dependency. Proper documentation includes birth certificates, marriage certificates, court orders, social security numbers, and dates of birth.

Informational Sessions will be held each weekday Monday, October 17, 2016 through Friday, October 28, 2016 from 10:00am until 2:00pm in the Commission Chambers located at City Hall.

HEALTH INSURANCE RATES FOR 2017

Medical Coverage - HMO	Monthly Contribution
Single Coverage	$ 708.60
Family	$ 1,823.95

Medical Coverage - POS	Monthly Contribution
Single Coverage	$ 905.43
Family	$ 2,330.52

VISION INSURANCE RATES FOR 2017

Vision	Monthly Contribution
Single Coverage	$ 6.60
Family	$16.03

If you have Life Insurance, we encourage you to review your beneficiary information, making any changes necessary. However, this can be done at any time during the year. **If you did not elect Life Insurance at the time of retirement, you may not do so now.**

Risk Management is available to answer your insurance questions. Please contact Judy Mehrmann, Employee Benefits Specialist at 954-838-4528 or Sofie Gilot, on-site AvMed Representative at 954-577-1142. Remember, enrollment forms must be returned to Risk Management by October 28, 2016 for an effective date of January 1, 2017. We will accept e-mailed (jmehrmann@sunrisefl.gov), hand deliver or mailed forms.

Sincerely

William Mason
Risk Manager

Attachments:

- Enrollment/Change Form
- Pension Deduction Authorization
- Vision Plan Summary
- Designation of Life Beneficiary Form
- Wellness Event Flyer
- Medicare Part D Notice
- Benefits Survey

City of Sunrise Florida
Group Medical, Dental and Vision Plan
OFFICE USE ONLY
Effective Date of Coverage:____/____/_____

__New Enrollment __Reinstate
__Open Enrollment __Change
Classification: **RETIREE**

Subscriber Information

Retiree Last Name	First Name	M.I.	Social Security Number*	Date of Birth	Gender __M __F

Mailing Address	Apt.	City	State	Zip	Phone ( ) _____- _____

Last Department/Division	Last Job Title			Email:

If this is a Change, Indicate Type: __Add Dependent(s) __Drop Dependent(s) __Drop Employee and Dependent(s), if any
(attach document for proof) **Changes must be made within 31 days of qualifying event, as per IRS Sec 125 guidelines**

__New address(as above), __New Name: From_____ to _____

This Change is due to: ___Marriage ___Birth ___Separation of Employment ___Other:_____ Date of Event: _____

Additional Information

Other than this Health Plan, will you and/or your family have other Health Insurance Coverage as of this date? __Yes __No Dental? __Yes __No

If yes, list Covered Person(s):_____

Insurance Company Name: _____ Do you or your spouse have Medicare? __Yes __No

Covered Individuals	**Medical-HMO**	**Medical-POS**	**Dental-HMO**	**Dental-HMO**	**Dental-PPO Low Option**	**Dental-PPO High Option**	**Vision**
Indicate your medical, dental and/or vision coverage options by placing an X in the appropriate ( )	**Indicate Option**	**Indicate Option**	**Indicate Option**	**Retiree Facility #**	**Indicate Option**	**Indicate Option**	**Indicate Option**
Single	( )	( )	( )		( )	( )	( )
Retiree and One Dependent*	**N/A**	**N/A**	( )	**N/A**	( )	( )	**N/A**
Family	( )	( )	( )	**N/A**	( )	( )	( )

*Eligible dependents are: spouse and/or natural, adopted or awarded child as defined in the plan document.

List below **all** eligible dependents you wish to cover on your medica,dental or vision plan. This enrollment form will replace all previously completed forms. Only those listed below will have coverage on the effective date of this enrollment or change.

Last Name	**First**	**M.I.**	**Date of Birth**	**Gender**	**Social Security Number***	**Coverage Selection**
(2)Spouse			MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(3) Dependent			MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(4) Dependent			MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(5) Dependent			MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(6) Dependent			MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____

Proper documents required: marriage certificate, birth certificate, hospital birth record, adoption award, medical child support order.

Authorization

I hereby (1) **REQUEST** coverage for the Group Medical, Dental and/or Vision Plan for which I am, or may become eligible; (2) authorize the Pension Administrator to make the necessary deductions for the contributions, if any, required for the Health Plan. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to any illness, injury, or medical history to the claims payor, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made directly to the hospital or physician for services rendered unless paid receipts are presented. *The social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Retiree Signature _____ **Date**_____

Declination - complete this section only if declining or canceling your single coverage

I hereby **DECLINE** ___**Medical** ___**Dental** ___**Vision** coverage. I realize that once I cancel my single medical and/or dental coverage, I may not elect the canceled coverage in the future. Coverage must be continued from the time of retirement and, if canceled, cannot be reinstated.

Retiree Signature _____ **Date**_____

CITY OF SUNRISE

PENSION DEDUCTION AUTHORIZATION

To Whom It May Concern:

This is authorization to deduct applicable insurance premiums to the City of Sunrise from my _____ pension each month, with an effective date of 01/01/2017.
(Pension Plan; Gen, Police, Fire)

Medical $_____ /Month

Vision $_____/Month

Dental $_____ /Month

Life $_____ /Month

_____ _____
Signature Date

_____ _____
Print Name Last 4 digits of
Social Security Number

Humana Vision 130

FLORIDA

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	Up to $130 20% off balance over $130	Up to $65
Standard plastic lenses[4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90, 80% of charge, then up to $120	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	Up to $130, 15% off balance over $130	Up to $104
• Disposable	Up to $130	Up to $104
• Medically necessary	$0	Up to $200

Humana Vision 130

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33
Optional benefits		

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.

[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.

[3] Discounts available on all frames except when prohibited by the manufacturer.

[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

[5] Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis [1].

[1] Thompson Media Inc.

Questions

Check out Humana.com

Call 1-866-995-9316 seven days a week: 8 a.m. to 6 p.m. Eastern Time Monday through Saturday, and 11 a.m. to 8 p.m. Sunday.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana®

BENEFICIARY DESIGNATION FORM

Life insurance Company of North America

CIGNA Group Insurance
Life · Accident · Disability

Employer Name CITY OF SUNRISE

Employee Name _____ **Employee Social Security #** _____

Current Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work Phone** _____ ***Please enter all dates in mm/dd/yyyy format.***

Primary and Contingent Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Basic Life Insurance, Life Insurance Company of North America – Policy No. FLX 962492				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Employee's Contingent Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**

Basic Accident Insurance, Life Insurance Company of North America – Policy No. OK 964123				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Contingent(s):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**

Please refer to page 2 to designate Beneficiaries for Voluntary Basic and Accident Insurance and to review *Guidelines for Designation of Beneficiaries*. If you need additional space, using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

Voluntary Life Insurance, Life Insurance Company of North America – Policy No. FLX 962492				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Employee's Contingent Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**

Voluntary Accident Insurance, Life Insurance Company of North America – Policy No. OK 964123				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**
Contingent(s):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (Total must equal 100%)**

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors – While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may wan to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary – You may designate a trust as a beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

Life Status Changes – We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

Community Property Laws – If you are married, reside in a community property state (Arizona, California, Hawaii, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature_____ Date _____/_____/_____

Owner Signature_____ Date_____/_____/_____

CITY OF SUNRISE FLORIDA

Please join us!

2016 Wellness Season Events

BROUGHT TO YOU BY RISK MANAGEMENT AND HUMAN RESOURCES

Wellness Season!

City Hall Events :

- Flu Shots
- Blood Pressure Check
- Total Cholesterol
- Glucose
- Triglycerides
- Health Education
- PSA Test
- AvMed Representative
- Benefits Specialist
- EAP
- ICMA
- Massage Therapist

Other Sites Events:

- Flu Shots
- Health Education
- AvMed Representative
- Benefits Specialist
- EAP
- Massage Therapist
- PSA Test (11/4 Event)

EVENT SCHEDULE

CITY HALL
COMMISSION CHAMBERS

All Sessions 10:00 am to 2:00 pm

Monday, October 17

Wednesday, October 19

Tuesday, October 25

Wednesday, October 26

ANNEX

Monday, October 31—9:00 am to 11:00 am

PUBLIC SAFETY BUILDING

Tuesday, November 1—10:00am to Noon

Tuesday, November 1—5:00 pm to 7:00 pm

Friday, November 4—3:00 pm to 6:30 pm

777 CORPORATE PARKWAY

Wednesday, November 2—10:00 am to 1:00 pm

- *DEPENDENTS WELCOME*
- *FREE EVENT!*
- *CONFIDENTAL RESULTS*
- *DOOR PRIZES!!!*
- *NO OUT OF POCKET COSTS FOR FLU SHOTS, TESTING, OR CONSULTATION*

AvMed Embrace better health.

CITY OF SUNRISE FLORIDA

AVMED CUSTOMER SERVICE

- *Covered services*
- *Pharmacy benefits*
- *Co-pays*
- *Providers and provider issues*
- *Network / Facilities*
- *Prior authorizations*
- *Billing questions*
- *Out of Area / PHCS Network*
- *Away From Home / Students*

On Site Client Services Rep

954.577.1142 *sofie.gilot@avmed.org*

Risk Management 3rd floor - City Hall
8am-4:30pm, Monday through Friday

OTHER CITY BENEFITS and Plan Services

- *Eligibility and enrollment*
- *Family status changes (marriage, divorce, child birth, adoption, loss of coverage)*
- *Deductions*
- *New Hire On-boarding*
- *Retiree Benefit Enrollment*
- *Dental*
- *Vision*
- *Life Insurance*
- *AFLAC*

Judy Mehrmann, Employee Benefits Specialist

954.838.4528 *jmehrmann@sunrisefl.gov*

Risk Management 3rd floor - City Hall
8:30am-4:30pm, Monday through Friday

Biometric Screening—Know Your Numbers

A biometric screening is a short assessment to obtain your health information. The information collected includes blood pressure, cholesterol levels, glucose (blood sugar) levels, and Body Mass Index (BMI).

If your health indicators fall outside of a good range, it may be the first warning sign you receive informing you of a potential health risk or problem.

Finding these warning signs early gives you the opportunity for proactive treatment options and lifestyle changes. As important as these health indicators are, they are not a mechanism for diagnosing or treating a disease. And they are not a replacement for regular medical examinations. We encourage you to speak promptly with your healthcare provider about your health indicators after your screening.

Important Notice from City of Sunrise About Your Prescription Drug Coverage and Medicare - 2016

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription coverage offered under the employee group medical insurance with City of Sunrise and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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 Sunrise has determined that the prescription drug coverage offered under the City of Sunrise's employee group medical insurance is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you have the right to keep your City of Sunrise prescription drug coverage under the employee group medical insurance and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from **October 15th** through **December 7th**. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your City of Sunrise's prescription coverage under the employee group medical coverage be aware that you and your dependents may not be able to get this coverage back unless you are eligible to apply at the next City of Sunrise's employee group medical open enrollment.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with City of Sunrise and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

Contact Judy Mehrmann at the City's Risk Management office for further information at (954) 838-4528. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if your prescription drug coverage through City of Sunrise changes from Creditable to Non-Creditable coverage status. You also may request a personalized copy of this same notice.

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 prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	September 30, 2016
Name of Entity/Sender:	City of Sunrise
Contact--Position/Office:	Judith Mehrmann, Employee Benefit Specialist
Address:	10770 W Oakland Park Blvd, 3rd Floor, Sunrise, FL 33351
Phone Number:	(954) 838-4528

INSURANCE BENEFITS SURVEY

The City of Sunrise is requesting your feedback on the health, dental, and vision insurance benefits offered to City employees. We would appreciate it if you would take a few moments to complete this survey and send your responses to Judy Mehrmann, Benefits Specialist, in City Hall or via email at jmehrmann@sunrisefl.gov. If you would like assistance completing this survey or have additional questions, please contact Judy at 954-838-4528. Thank you in advance for completing this survey to ensure that we are aware of opportunities for improvement.

1. Are you currently enrolled in the City's health, dental, or vision insurance plans?

☐ Yes. If Yes, which plan(s)_____ ☐ No. If No, why not?_____

2. How satisfied are you with the quantity & quality of the information you receive about your insurance plan(s)?

☐ Extremely satisfied ☐ Satisfied ☐ Not satisfied ☐ Extremely dissatisfied

3. How satisfied are you with the group of doctors you can choose from under your health insurance plan?

☐ Extremely satisfied ☐ Satisfied ☐ Not satisfied ☐ Extremely dissatisfied

4. How satisfied are you with the group of doctors you can choose from under your dental insurance plan?

☐ Extremely satisfied ☐ Satisfied ☐ Not satisfied ☐ Extremely dissatisfied

5. How satisfied are you with the group of doctors you can choose from under your vision insurance plan?

☐ Extremely satisfied ☐ Satisfied ☐ Not satisfied ☐ Extremely dissatisfied

6. How satisfied are you with the range of services available by your insurance plan(s)?

☐ Extremely satisfied ☐ Satisfied ☐ Not satisfied ☐ Extremely dissatisfied

7. How satisfied are you with the overall cost of the City's insurance plans (including monthly premiums, co-pays, deductibles, etc.)?

☐ Extremely satisfied ☐ Satisfied ☐ Not satisfied ☐ Extremely dissatisfied

8. Have you experienced any challenges using the City's health, dental, or vision insurance plans?

☐ Yes. If Yes, please briefly explain_____ ☐ No

9. Overall, how would you rate each of the insurance plans in terms of experience and value of the services?

	Great	Good	Average	Fair	Poor
Health/Medical Insurance	☐	☐	☐	☐	☐
Dental Insurance	☐	☐	☐	☐	☐
Vision Insurance	☐	☐	☐	☐	☐

10. If you are not satisfied with your insurance benefits, please explain the reason(s). Please also tell us how we can improve our benefit package for you and your family.