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HEALTH INSURANCE

HEALTH INSURANCE

HealthPartners will continue to provide City-sponsored health care benefits for City of Saint Paul employees and their families in 2016. HealthPartners offers high quality health care and has been awarded “Excellent” Accreditation from the National Committee for Quality Assurance (NCQA) for 12 years in a row. NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America’s health care. HealthPartners, a health plan whose mission is to improve health, offers comprehensive benefits, including coverage for preventive care when you use the network providers. HealthPartners provides online tools and phone resources to help you select your health care providers and get the care that best meets your needs. There are also tools and resources that provide information and support to help you improve your health. You have a choice of two HealthPartners plans, with different levels of coverage and premiums, so you can choose the benefits coverage and premium that is right for you and your family. These Plans are:

- ◆ HealthPartners Open Access Choice with Deductible
- ◆ Distinctions Plan

Eligibility

Eligible employees are those whose title and employment status satisfy the eligibility provision of a collective bargaining unit agreement or applicable City Council resolution. Each eligible employee selects one of these plans. If family coverage is elected, each family member may select a different clinic from the plan's network.

Dependent children can be on your medical plan to age 26. Please note that although dependent children can be enrolled in your health plan, there may be tax implications.

Unmarried fathers with single coverage can change to family coverage within 30 days of the child’s birth, with family coverage effective on the date of birth. Paternity may be established at a later time due to a court order declaring paternity or a Minnesota Voluntary Recognition of Parentage form being filed with the Department of Health (or the equivalent if outside of Minnesota). In that situation, the child’s effective date is the date of the court order or the date the Minnesota Voluntary Recognition of Parentage form is filed.

The City intends to conduct random, periodic dependent audits requiring substantiating documentation. You will be responsible for repayment of premiums and claims for any ineligible dependents.

Plans and Monthly Premiums

The 2016 premiums vary according to the plan you select. The amount of the City’s contribution toward your health insurance premium is determined by your collective bargaining unit agreement or applicable City Council Resolution. See BenefitReady for your contributions.

HealthPartners Open Access Choice with Deductible

In the HealthPartners Open Access Choice with Deductible Plan, you do not need to select a primary clinic or physician and you may see any provider listed in the directory without a referral. The HealthPartners Open Access Network in alliance with CIGNA HealthCare offers direct, national access to more than 950,000 doctors and other care providers and 6,000 hospitals. This plan also features an out-of-network benefit that allows direct access to any licensed provider worldwide. You receive the highest benefit level when you use a network provider, though you may opt to see non-network providers at a lower benefit level. Members first pay an annual deductible for in-network and out-of-network care, and then most benefits are covered at 80 percent when using the HealthPartners Open Access Network. After the annual out-of-pocket maximum is met, coverage is 100 percent for eligible expenses.

- ◆ Single: \$577.05
- ◆ Family: \$1,508.60

Distinctions Plan

The Distinctions Plan combines the HealthPartners Open Access Network with out-of-network coverage. This plan rates providers by the quality and cost of their care. You pay less to see Benefit Level I providers and more for Benefit Level II providers.

- ◆ Single: \$712.04
- ◆ Family: \$1,861.99

Enrolling in one of the two plan choices does not guarantee services by a particular provider. If you want to be certain of receiving care from a specific doctor, you should contact that doctor to ask whether or not the doctor is a HealthPartners network provider and whether or not the doctor is accepting additional patients. Access to health care services does not guarantee access to a particular type of doctor. Contact Member Services at 952-883-5000 or 800-883-2177 for specific information about access to different kinds of doctors.

Networks

Each available plan features in-network and out-of-network coverage. Following are brief descriptions of each network and a list of plans with which the network is available. For a complete directory listing, call Member Services at 952-883-5000 or 800-883-2177.

HealthPartners Open Access Network

The HealthPartners Open Access Network in alliance with CIGNA HealthCare offers direct, national access to more than 950,000 doctors and other care providers and 6,000 hospitals. The HealthPartners Open Access Choice with Deductible Plan uses this network. Members who choose this plan do not choose a primary clinic and do not need referrals for specialty care. You can choose to go anywhere in the network any time you need care, including Mayo Clinic specialty providers.

Distinctions Network

The Distinctions Plan also uses the HealthPartners Open Access network, including Mayo Clinic Specialty providers. The Distinctions plan allows you to choose doctors and clinics based on what's most important to you. HealthPartners rates providers using the industry's most sophisticated methods, so you can easily learn which providers offer the best cost and quality. This helps you make an informed choice when you want the best care for the best value. The Distinctions plan also provides access to CIGNA HealthCare's national network.

Out-of-Network Care

Out-of-network benefits are available with each plan after you satisfy an annual deductible (if necessary). The plan then pays 65 percent or 80 percent of the fee schedule amount for many health care services. However, routine physical and eye examinations and well-child care are not covered with out-of-network providers. You are responsible for payment to all out-of-network providers and must submit a claim to be reimbursed for covered services.

Out-of-network professional claims are covered at 140 percent of the Medicare fee schedule.

Enrollment

You must enroll using BenefitReady, the City's online benefit system, at csp.benefitready.com. If you wish to elect family coverage, click on "Select A Plan That Includes My Dependents". If you elect coverage that includes your dependents, choose each dependent to be covered by clicking on the box next to their name and then follow the instructions to ensure they are added.

The election that you make during Open Enrollment is for the entire plan year (January 1, 2016 through December 31, 2016). You may change your election only if you experience a status change event, as defined on [page 40](#).

Clinics

Your medical plan provides preventive dental benefits; for more extensive dental coverage, you can enroll in the optional HealthPartners Dental Distinctions plan (see [page 61](#) for details). If you choose the optional HealthPartners Dental Distinctions plan, you can choose a different dental clinic than the one you chose under your medical plan.

Members choosing the HealthPartners Open Access Choice with Deductible plan or the Distinctions medical plan do not need to select a primary medical clinic.

VIRTUWELL

virtuwell is your 24/7 online clinic. Get a treatment plan and a prescription if you need one, right from your home or office. And with your HealthPartners plan, you get three free visits per family member!



A virtuwell visit – quick, convenient, safe

1. A virtuwell visit starts with a **quick online interview** that checks your history and makes sure the problem isn't serious.
2. Next, a **certified nurse practitioner** will review your case and write your treatment plan. You'll get an email or text the moment your plan is ready – usually within thirty minutes or less.
3. If you need a **prescription**, it will be sent to your pharmacy of choice.
4. If you need to speak with a nurse practitioner about your plan, they're **available 24/7**.

Treats many common conditions

virtuwell treats things like:

- Sinus infections
- Pink eye
- Bladder infections
- Upper respiratory infections
- Rashes and other skin irritations
- And more...

Find the full list at virtuwell.com/conditions

Questions?

Answers, videos and information can be found at virtuwell.com.

HealthPartners Preferred Drug List (Formulary)

HealthPartners Preferred Drug List (Formulary) is a list of drugs that are covered at the highest level under your health plan. The formulary, which is reviewed and updated throughout the year, lists prescription drugs that have been evaluated for safety, effectiveness, side effects, ease of use and affordability. View the HealthPartners Preferred Drug List online at healthpartners.com/pharmacy.

When your personal physician prescribes something for you, it's a good idea to ask if the medication is on the HealthPartners Preferred Drug List. If it isn't, you may want to ask your physician whether a preferred drug list item would be suitable for you. In some cases, you may need a drug that is not on the preferred drug list. Your doctor can request that an exception be made so that the non-preferred drug list item can be covered. The clinical pharmacy staff reviews all these requests and decides when an exception is warranted for coverage. Generally, the decision will be made the same day your doctor makes the request.

Generic/Brand Pharmacy Benefit

Your HealthPartners plan features a generic/brand pharmacy benefit. This means that:

- ◆ If you receive a generic drug at the pharmacy, you will pay \$10 for the prescription.
- ◆ If a generic drug is not available and you receive a brand name drug, you will pay the brand copay.
- ◆ If a generic drug is available, but you choose the brand name drug instead, you will pay the brand copay plus the cost difference between the generic and brand name prescriptions.

Want to find out how much your prescription will cost before you get to the pharmacy? Log on to your *myHealthPartners* account at healthpartners.com. The HealthPartners Drug Cost Calculator will tell you the cost of your prescription based on your actual pharmacy benefit. The calculator also gives the cost for therapeutically equivalent and generic drugs that are less expensive than the brand name drug. If you don't have access to the internet, simply call Member Services at 952-883-5000 or 800-883-2177.

Provider Information

Please remember that the doctors and clinics available with any health plan are continually changing. The most current network information (updated weekly) is available online. Visit healthpartners.com

As always, if you have any questions about your HealthPartners networks or benefits, or need assistance with choosing a clinic, HealthPartners Member Services is available to help. To get information about your provider network or benefits, call 952-883-5000, toll-free at 800-883-2177 or 952-883-5127 for the hearing impaired, any time during the year.

Identification Cards

Members will receive a new ID card for 2016 if you are new to the plan or switching plans. Your Group Membership Contract and Schedule of Payments will be available online through healthpartners.com as well as through HealthPartners Member Services Department.

Termination of Employment or Leave of Absence

See [page 85](#) for information on continuation of benefits.

Coverage

Benefit summaries for each of the available plans are on [pages 10 through 15](#). A quick-reference plan comparison is on [page 18](#). These are intended as a general guide to your health insurance benefits. Full details of the plans are in your Group Membership Contract and Schedule of Payments.

Emergency Care

A medical emergency involves the sudden, life-threatening onset of illness or injury which demands medical attention, and when failure to get immediate care could cause serious harm. Some examples of medical emergencies are: uncontrollable bleeding; confusion or loss of consciousness, especially after a head injury; severe shortness of breath or difficulty breathing; apparent heart attack (severe chest pain, sweating and nausea); and bone fractures.

If you experience a medical emergency within the service area, call 911 or go to the hospital affiliated with your primary care clinic. If you can't get to the hospital affiliated with your primary care clinic, then go to the nearest hospital for care. If you are hospitalized, notify your clinic within 48 hours or as soon thereafter as possible.

If you experience a medical emergency outside the service area, call 911 or go to the nearest hospital emergency room for treatment. If you are hospitalized, contact the HealthPartners CareCheck® program at 952-883-5800 or 800-942-4872 within 48 hours or as soon thereafter as possible.

Urgent Care

Urgent medical problems are those that, while not life-threatening, should be attended to on the same day or fairly soon. For example: ear infections in children, cuts that may require stitches, or an acute asthma episode. For urgent care needed during clinic hours, please call your clinic. For urgent care after your clinic's regular hours, you have several options:

- ◆ Call your clinic's after-hours line;
- ◆ Call the HealthPartners CareLinesSM nurse line at 612-339-3663 or 800-551-0859 to speak to a nurse trained to review your symptoms and explain your treatment options; or
- ◆ Walk into any of the urgent care centers listed in the network directories

Definition of Terms

The benefit summaries contain several terms which are defined below:

- ◆ **Coinsurance:** The percentage of costs the member must pay when receiving services, usually after paying a deductible.
- ◆ **Copay:** The fixed amount or percentage of eligible expenses the member must pay to the provider each time services are received.
- ◆ **Deductible:** The amount of eligible expenses members must pay each year before claims are reimbursable under the contract.
- ◆ **Discounts:** HealthPartners negotiates reduced rates with network providers. Those discounts are passed along to members who use a network provider.

- ◆ **Eligible Expense:** The charge billed by the provider for services covered by the plan.
- ◆ **Out-of-Pocket Maximum:** Payments you make for covered services (copays, coinsurance and deductibles) are “out-of-pocket” expenses. Once you reach the limit specified by your plan, the plan covers 100 percent of additional eligible costs for the remaining calendar year.
- ◆ **Preventive Health Care:** Routine health exams, immunizations, pre-natal and post-natal care and exams, routine eye and hearing exams, routine screening procedures for cancer. Note: treatment of a condition or illness during a routine exam is not preventive health care; it is covered as an office visit.

Plan descriptions

The following pages provide a brief overview and benefit summaries of each of the HealthPartners plans available to you for 2016. These are intended as a general guide to your health insurance benefits. Full details of the plans are in your Group Membership Contract and Schedule of Payments. You can also contact HealthPartners Member Services at 952-883-5000, or visit with a HealthPartners representative at any of the Open enrollment information sessions.

HealthPartners Open Access Choice with Deductible

In the HealthPartners Open Access Choice with Deductible Plan, you pay an annual deductible. Once the deductible is met, most benefits are covered at 80 percent when using the HealthPartners Open Access Network; you pay 20 percent of the costs. After the annual out-of-pocket maximum has been reached, HealthPartners pays 100 percent.

Open Access Choice with Deductible

Monthly Premium:	Single: \$577.05 Family: \$1,508.60
Network:	Open Access Network. Out-of-network benefits are also available.
Annual Deductible:	\$2,500 per person, \$3,500 per family. A family deductible can be reached by two or more members reaching \$3,500 (i.e., any combination of family members can cumulatively reach the \$3,500 deductible amount).
	<i>Example –</i>
	Member #1 = \$ 700 Member #2 = \$1000 Member #3 = \$ 900 Member #4 = \$ 900 \$ 3,500 (the family deductible is met)
Annual Medical Out-of-Pocket Maximum:	Any deductible paid will apply towards the out-of-pocket maximum. Using the above example, the family annual out-of-pocket maximum is met even though none of the individual members have met the per person out-of-pocket maximum
Preventive Health Care:	Deductible does not apply. HealthPartners pays 100% when you use a provider in the HealthPartners Open Access Network.
Prescription Drugs:	Prescription copays do not apply to the deductible for in-network coverage, but do apply to the out-of-pocket maximum. The deductible applies when using out-of-network pharmacies, however. This coverage is the same as the Distinctions plan; both use the same pharmacy network.
Copay and Out-of-Pocket Copay Changes:	The brand Rx copay is going from \$20 to \$35.

HealthPartners Open Access Choice with Deductible

PARTIAL LISTING OF COVERED SERVICE	HEALTHPARTNERS OPEN ACCESS	OUT-OF-NETWORK
	<i>When care is provided by a HealthPartners Open Access provider.</i>	<i>When care is provided by an out-of-network provider</i>
Lifetime maximum	Unlimited	\$1,000,000
Calendar year deductible	\$2,500 per person; \$3,500 per family	\$3,000 per person; \$5,500 per family
Calendar year out-of-pocket maximum, medical and prescription combined	\$3,500 per person; \$3,500 per family	\$5,500 per person; \$7,000 per family
Preventive Health Care		
▪ Routine physical & eye examinations, well-child care	You pay nothing	No coverage
▪ Prenatal and postnatal care	You pay nothing	You pay 35% after deductible
Office Visits		
▪ Illness or injury	You pay 20% after deductible	You pay 35% after deductible
▪ Physical, occupational, & speech therapy	You pay 20% after deductible	You pay 35% after deductible 20 visits per year
▪ Chiropractic care (neuromusculo- skeletal conditions only)	You pay 20% after deductible	You pay 35% after deductible 20 visits per year
▪ Mental health care	You pay 20% after deductible	You pay 35% after deductible
▪ Chemical health care	You pay 20% after deductible	You pay 35% after deductible
Convenience Care		
▪ Convenience Care, Minute Clinic	You pay 20% after deductible	You pay 35% after deductible
▪ Virtuwel (online care)	First three visits free, then same as convenience care benefit	You pay 100% - No coverage
Inpatient Hospital Care		
▪ Illness or injury	You pay 20% after deductible 365 days per period of confinement	You pay 35% after deductible *
▪ Mental health care	You pay 20% after deductible 365 days per period of confinement	You pay 35% after deductible*
▪ Chemical health care	You pay 20% after deductible 365 days per period of confinement	You pay 35% after deductible *
Outpatient Care		
▪ Scheduled outpatient procedures	You pay 20% after deductible	You pay 35% after deductible *
▪ Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)	You pay 20% after deductible	You pay 35% after deductible *
Emergency Care		
▪ Urgently needed care at an urgent care Clinic or medical center	You pay 20% after deductible	HealthPartners in-network Emergency Care benefit
▪ Emergency care at a hospital ER	You pay 20% after deductible	HealthPartners in-network Emergency Care benefit
▪ Ambulance	You pay 20% after deductible	HealthPartners in-network benefit
Home Health Care		
▪ Physical, speech, occupational, & respiratory therapy, & home health aides	You pay 20% after deductible 120 visits per year	You pay 35% after deductible 60 visits per year
Durable Medical Equipment		
▪ Durable medical equipment & prosthetic devices	You pay 20% after deductible	You pay 35% after deductible 60 visits per year
Dental Care		
▪ Treatment to restore damage done to sound, natural teeth as a result of accidental injury	You pay 20% after deductible	80% coverage after \$50 deductible up to a \$300 maximum
▪ Preventive care for all ages, x-rays, exams, cleaning, fluoride treatment	You pay nothing	No coverage
*CareCheck[®] Service		

*To receive maximum benefits for hospitalizations including medical emergencies and same-day surgeries outside the HealthPartners Network, you must notify CareCheck[®] at 952-883-5800 or 800-942-4872. A utilization management specialist will review your proposed treatment plan, determine length of stay, approve additional days when needed, and review the quality and appropriateness of the care you receive. Benefits will be reduced by 20 percent if CareCheck[®] is not notified. Please refer to a Group Membership Contract for further information.

Formulary Prescription Drugs (up to a 30-day supply, or one cycle of oral contraceptives; and up to a 90-day supply for mail order)	HealthPartners Participating Pharmacy Benefit	Non-Participating Pharmacy Benefit
Tobacco cessation products are limited to coverage in-network and a 180-day supply per year		
<ul style="list-style-type: none"> ▪ Retail Pharmacy <ul style="list-style-type: none"> ▪ Generic ▪ Brand 	<p>You pay \$10</p> <p>You pay \$35</p>	<p>You pay 35% after deductible*</p> <p>You pay 35% after deductible*</p>
<ul style="list-style-type: none"> ▪ HealthPartners Mail Order Pharmacy <ul style="list-style-type: none"> ▪ Generic ▪ Brand 	<p>You pay \$20 - three-month supply</p> <p>You pay \$70 - three-month supply</p>	
<ul style="list-style-type: none"> ▪ Specialty Drugs 	80% coverage up to a \$200 maximum per prescription per month	You pay 35% after deductible*
<ul style="list-style-type: none"> ▪ Allergy injections 	You pay nothing	You pay 35% after deductible*
<ul style="list-style-type: none"> ▪ Immunizations 	You pay nothing	You pay 35% after deductible*

As part of the Patient Protection and Affordable Care Act, HealthPartners is required to provide you with an easy-to-understand summary about their health plan's benefits and coverage. The new regulation is designed to help you better understand and evaluate your health insurance choices.

The new summaries include:

- A short, plain language **S**ummary of **B**enefits and **C**overage, or SBC
- A uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment"

To view the SBC, log onto csp.BenefitReady.com, click on the "Knowledge Base" icon.

Distinctions Plan

Your cost for care depends on who you see. We rate providers by the quality and cost of their care. You pay less to see Benefit Level I providers and more for Benefit Level II providers.

Distinctions Plan	
Monthly Premium:	Single: \$ 712.04 Family: \$ 1,861.99
Network:	The HealthPartners Open Access Network. Out-of-network benefits are also available.
Annual Deductible:	No deductible when you use the HealthPartners Open Access Network or the CIGNA HealthCare Network when traveling within the United States.
Annual Medical Out-of-Pocket Maximum:	Copays and coinsurance will apply towards the out-of-pocket maximum.
Preventive Health Care:	HealthPartners pays 100% when you use the HealthPartners Open Access Network.
Prescription Drugs:	Not subject to the annual deductible for in-network coverage. The deductible applies when using out-of-network pharmacies, however. This coverage is the same as the Open Access w/Deductible plan; both plans use the same pharmacy network.
Copay and Out-of-pocket Maximum Changes:	No changes.

DISTINCTIONS

PARTIAL LISTING OF COVERED SERVICE	HEALTHPARTNERS OPEN ACCESS NETWORK	OUT-OF-NETWORK
	<i>When care is provided or authorized by your HealthPartners personal provider</i>	<i>When care is provided by an out-of-network provider</i>
Lifetime maximum	Unlimited	\$1,000,000
Calendar year deductible	None	\$300 per person; \$900 per family
Calendar year medical out-of-pocket maximum	\$3,000 per person; \$5,000 per family	\$4,000 per person; \$6,000 per family
Calendar year prescription out-of-pocket maximum	\$500 per person; \$1,000 per family combined for all covered prescriptions	
Preventive Health Care		
▪ Routine physical & eye examinations, well-child care	You pay nothing	No coverage
▪ Prenatal and postnatal care	You pay nothing	You pay 35% after deductible
Office Visits		
▪ Illness or injury	You pay \$35 per visit for Benefit Level 1 You pay \$50 per visit for Benefit Level 2	You pay 35% after deductible
▪ Physical, occupational, & speech therapy	You pay \$35 per visit for Benefit Level 1 You pay \$50 per visit for Benefit Level 2	You pay 35% after deductible 20 visits per year
▪ Chiropractic care (neuromusculo-skeletal conditions only)	You pay \$35 per visit for Benefit Level 1 You pay \$50 per visit for Benefit Level 2	You pay 35% after deductible 20 visits per year
▪ Mental health care	You pay \$35 per visit	You pay 35% after deductible
▪ Chemical health care	You pay \$35 copay per visit	You pay 35% after deductible
Convenience Care		
▪ Convenience Care, Minute Clinic Virtuwell (online care)	You pay \$15 copay per visit First three visits free, then same as convenience care benefit	You pay 35% after deductible
Inpatient Hospital Care		
▪ Illness or injury	You pay nothing	You pay 35% after deductible *
▪ Mental health care	You pay nothing	You pay 35% after deductible *
▪ Chemical health care	You pay nothing	You pay 35% after deductible *
Outpatient Care		
▪ Scheduled outpatient procedures	You pay nothing	You pay 35% after deductible *
▪ Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)	You pay 20%	You pay 35% after deductible *
Emergency Care		
▪ Urgently needed care at an urgent care Clinic or medical center	You pay \$50 per visit	HealthPartners in-network Emergency Care benefit
▪ Emergency care at a hospital ER	You pay \$55 per visit	HealthPartners in-network Emergency Care benefit
▪ Ambulance	You pay 20%	HealthPartners in-network benefit
Home Health Care		
▪ Physical, speech, occupational, & respiratory therapy & home health aides	You pay \$25 per visit	You pay 35% after deductible
Durable Medical Equipment		
▪ Durable medical equipment & prosthetic devices	You pay 20%	You pay 35% after deductible
Dental Care		
▪ Treatment to restore damage done to sound, natural teeth as a result of accidental injury	You pay 20%	80% coverage after \$50 deductible up to a \$300 maximum
▪ Preventive care for all ages, x-rays, exams, cleaning, fluoride treatment	You pay nothing	No coverage
* CareCheck® Service		

*To receive maximum benefits for hospitalizations including medical emergencies and same-day surgeries outside the HealthPartners Network, you must notify CareCheck® at 952-883-5800 or 800-942-4872. A utilization management specialist will review your proposed treatment plan, determine length of stay, approve additional days when needed, and review the quality and appropriateness of the care you receive. Benefits will be reduced by 20 percent if CareCheck® is not notified. Please refer to a Group Membership Contract for further information.

Formulary Prescription Drugs (up to a 30-day supply; or one cycle of oral contraceptives; and up to a 90-day supply for mail order)	HealthPartners Participating Pharmacy Benefit	Non-Participating Pharmacy Benefit
Tobacco cessation products are limited to coverage in-network and a 180-day supply per year		
Retail Pharmacy		
▪ Generic	You pay \$10	You pay 35% after deductible
▪ Brand	You pay \$20	You pay 35% after deductible
Mail Order Pharmacy		
▪ Generic	You pay \$20 - three-month supply	
▪ Brand	You pay \$40 - three-month supply	
Specialty Drugs	80% coverage up to a \$200 maximum per prescription per month	You pay 35% after deductible

As part of the Patient Protection and Affordable Care Act, HealthPartners is required to provide you with an easy-to-understand summary about their health plan's benefits and coverage. The new regulation is designed to help you better understand and evaluate your health insurance choices.

The new summaries include:

- A short, plain language Summary of Benefits and Coverage, or SBC
- A uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment"

To view the SBC, log onto csp.BenefitReady.com, click on the "Knowledge Base" icon.

PLAN COMPARISON

PLAN COMPARISON

The following page is a quick-reference plan comparison to assist you in identifying plan design differences. The list of benefits is a condensed version of the benefit summaries found in the previous section.

City of Saint Paul 2016 Plan Comparison

HEALTH SERVICE	OPEN ACCESS CHOICE PLAN WITH DEDUCTIBLE		DISTINCTIONS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime maximum	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Calendar Year Deductible (applies to Medical OOP Max)	\$2,500 per person \$3,500 per family	\$3,000 per person \$5,500 per family	None	\$300 per person \$900 per family
Calendar Year Out of Pocket Maximum (once OOP Max is met coverage is 100%)	\$3,500 per person \$3,500 per family	\$5,000 per person \$7,000 per family	\$3,000 single \$5,000 family	\$4,000 per person \$6,000 per family
Calendar year Prescription Out-of-Pocket Maximum (once OOP Max is met coverage is 100%)	Combined with Medical Out-of-pocket Maximum		\$500 per person; \$1,000 per family Combined in and out-of-network	
Preventive Health Care	100% coverage	No Coverage	100% coverage	No Coverage
Office Visits Illness or Injury Therapies: Physical, Occupational, Speech	80% after deductible	65% after deductible	\$35 copay for Benefit Level 1 \$50 copay for Benefit Level 2	65% after deductible
Chiropractic Services	80% after deductible	65% after deductible	\$50 copayment	65% after deductible
Mental Health Chemical Health	80% after deductible	65% after deductible	\$35 copayment	65% after deductible
Inpatient Hospital Care	80% after deductible	65% after deductible	100% coverage	65% after deductible
Outpatient Hospital Care	80% after deductible	65% after deductible	100% coverage	65% after deductible
MRI/CT	80% after deductible	65% after deductible	80% coverage	65% after deductible
Convenience Care	80% after deductible	65% after deductible	\$15 copayment	65% after deductible
Virtuwell (online care)	First 3 visits -Free; 80% coverage thereafter	No Coverage	First 3 visits -Free; \$15 copayment thereafter	No Coverage
Emergency Care Urgent Care Hospital ER Ambulance	80% after deductible	HealthPartners in-network Emergency Care benefit HealthPartners in-network benefit	\$50 copayment \$55 copayment 80% coverage	HealthPartners in-network Emergency Care HealthPartners in-network benefit
Prescription Drugs	\$10 generic formulary drugs; \$35 brand formulary drugs	65% after deductible	\$10 generic formulary drugs; \$20 brand formulary drugs	65% after deductible
Specialty Drugs	80% coverage; member pays a maximum copayment of \$200 per prescription per month	65% after deductible	80% coverage; member pays a maximum copayment of \$200 per prescription per	65% after deductible
Preventive Dental	100% coverage	No Coverage	100% coverage	No coverage
Special Oral Surgery	80% after deductible	65% after deductible	80% coverage	65% after deductible
Rates				
▪ Single	\$577.05		\$712.04	
▪ Family	\$1,508.60		\$1,861.99	

Exclusions

Your health care plan doesn't cover all health care expenses. Below is a summary of items that are excluded or limited. Please refer to your Group Membership Contract for specific information about excluded services and supplies, or call HealthPartners Member Services at 952-883-5000 or 800-883-2177.

- ◆ Treatment, services or procedures that are experimental, investigative or not medically necessary
- ◆ Dental care or oral surgery*
- ◆ Non-rehabilitative chiropractic services
- ◆ Eyeglasses, contact lenses, hearing aids (over age 18) and their fittings
- ◆ Vocational rehabilitation; recreational or educational therapy
- ◆ Private-duty nursing; rest, respite and custodial care*
- ◆ Physical, mental or substance-abuse examinations done for or ordered by third parties
- ◆ Sterilization reversal and artificial conception processes*
- ◆ Cosmetic surgery*

* Except as specifically described in the Group Membership Contract

In addition to the exclusions and limitations listed above, **out-of-network coverage also excludes preventive health care services.**

Utilization Management Programs

Part of helping HealthPartners members stay healthy is making sure they get the care they need when they need it. To help coordinate effective, accessible and high quality health care, HealthPartners uses utilization management programs. These programs are based on the study of patient populations to evaluate appropriate levels of care. They use guidelines for the best medical practices based on the most up-to-date medical evidence.

HealthPartners utilization management programs include activities to reduce the underuse, overuse and misuse of health services. These programs include:

- ◆ Inpatient concurrent review and care coordination to ensure a safe and timely transition from the hospital to outpatient care
- ◆ Best practice for selected kinds of care
- ◆ Outpatient case management to provide care coordination
- ◆ The CareCheck program to coordinate out-of-network hospitalizations

Prior approval is required for a small number of services and procedures. Review prior approval information healthpartners.com and/or call HealthPartners Member Services. Typically, your doctor will request this approval on your behalf. Decisions are based on coverage criteria that are posted on the website and available from Member Services.

HealthPartners does not employ incentives that encourage barriers to care and service. HealthPartners rewards doctors who achieve the highest levels of quality and service to patients through its Partners in Quality Programs: Partners in Excellence and Partners in Progress.

The Partners in Excellence program offers bonus awards to primary care and specialty clinics achieving exceptional results on specific quality, satisfaction, efficiency and health information technology targets.

The Partners in Progress program integrates financial incentives for quality improvement into provider contracts. Partners in Progress blends payment for quality and payment for process into market-based reimbursement rates for primary care providers, specialists, hospitals, retail pharmacies and physical therapy providers. Health plan payments are set aside and paid if providers meet their individual targets.

HealthPartners Ranks Highest in Quality

HealthPartners delivers the greatest cost, care and service. HealthPartners unique partnership with providers, employers and most importantly, members, allows them to actively connect members with health and wellness support, engage members in health care decisions and deliver the best care at the best cost.

HealthPartners success has been recognized by third party organizations.

HealthPartners is the number one commercial health plan in Minnesota for 10 straight years according to the National Committee for Quality Assurance's Health Insurance Plan Rankings 2014-2015. Additionally, HealthPartners has had the highest overall member rating of any health plan in Minnesota for eight years running.

Service Area

The HealthPartners areas of service and networks of medical providers continue to grow, but access to all provider types is not guaranteed. Contact HealthPartners Member Services at 952-883-5000 or 800-883-2177 for current lists.

Improved Access for Appointments, Direct Access to Providers

HealthPartners Clinics offer same-day appointments. Members may call seven days a week to schedule an appointment at a HealthPartners Clinic or may schedule an appointment online through their *myHealthPartners* account. In addition, HealthPartners members who are enrolled in a primary clinic do not need a referral to see a specialist within their plan network.

Disease Management Programs

HealthPartners offers condition management services that focus on people who have health conditions. These programs proactively identify individuals who are at high risk for medical conditions and provide special personalized support to them in managing their conditions.

The HealthPartners condition management services offer a unique health and medical management approach that improves your health and lowers your overall health care costs.

HealthPartners condition management programs include care for the following conditions:

- ◆ Asthma
- ◆ Cancer
- ◆ Chronic obstructive pulmonary disease (COPD)
- ◆ Coronary artery disease (CAD)
- ◆ Depression and alcohol use disorder
- ◆ Diabetes
- ◆ Heart Failure
- ◆ Pregnancy or planning a pregnancy
- ◆ Rare and Chronic Diseases:
 - Amyotrophic Lateral Sclerosis (ALS)
 - Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
 - Cystic Fibrosis
 - Dermatomyositis
 - Gaucher's Disease
 - Hemophilia
 - Multiple Sclerosis
 - Myasthenia Gravis
 - Parkinson's Disease
 - Polymyositis
 - Rheumatoid Arthritis
 - Scleroderma
 - Sickle Cell Disease
 - Systemic Lupus Erythematosus (SLE)

Health and Wellness Programs

HealthPartners health improvement programs provide health and well-being services to members. HealthPartners offers programs that make it easy for you to improve your health. Health improvement programs come in a variety of formats and cover several topics, such as:

Frequent Fitness Program

Through the Frequent Fitness program, HealthPartners encourages you to work out to get – or stay – fit. Eligible members who join a Frequent Fitness participating facility and work out a minimum of 12 times per month qualify for a \$20 reimbursement on monthly dues. Some participating facilities also reduce or waive their initial joiner's fee. View a complete list of participating clubs at healthpartners.com/discounts.

Healthy Discounts

This expanding list of programs allows members – including those who can't or don't want to join a health club – to get discounts on tools and services to help you be as healthy as you can be. Simply show your HealthPartners Member ID card to participating retailers to receive Healthy Discounts on exercise equipment, classes, snowboard and ski equipment, spa and wellness services and much more. Please note, programs may change throughout the year. For the most updated list, visit healthpartners.com/discounts.

Provider reimbursement information for medical plans

Our goal in reimbursing providers is to provide affordable care for our members while encouraging quality care through best care practices and rewarding providers for meeting the needs of our members. Several different types of reimbursement arrangements are used with providers. All are designed to achieve that goal.

Some providers are paid on a “**fee-for-service**” basis, which means that the health plan pays the provider a certain set amount that corresponds to each type of service furnished by the provider.

Some providers are paid on a “discount” basis, which means that when a provider sends us a bill, we have negotiated a reduced rate on behalf of our members. We pay a predetermined percentage of the total bill for services.

Sometimes we have “case rate” arrangements with providers, which means that for a selected set of services the provider receives a set fee, or a “case rate,” for services needed up to an agreed upon maximum amount of services for a designated period of time. Alternatively, we may pay a “case rate” to a provider for all of the selected set of services needed during an agreed upon period of time.

Sometimes we have “withhold” arrangements with providers, which means that a portion of the provider’s payment is set aside until the end of the year. The year-end reconciliation can happen in one or more of the following ways:

- Withholds are sometimes used to pay specialty, referral or hospital providers who furnish services to members. The provider usually receives all or a portion of the withhold based on performance of agreed upon criteria, which may include patient satisfaction levels, quality of care and/or care management measures
- Some providers — usually hospitals — are paid on the basis of the diagnosis that they are treating; in other words, they are paid a set fee to treat certain kinds of conditions. Sometimes we pay hospitals and other institutional providers a set fee, or “**per diem**”, according to the number of days the patient spent in the facility.
- Some providers — usually hospitals — are paid according to Ambulatory Payment Classifications (APCs) for outpatient services. This means that we have negotiated a payment level based on the resources and intensity of the services provided. In other words, hospitals are paid a set fee for certain kinds of services and that set fee is based on the resources utilized to provide that service.
- Occasionally our reimbursement arrangements with providers include some **combination** of the methods described above. For example, we may pay a case rate to a provider for a selected set of services needed during an agreed upon period of time, or for services needed up to an agreed upon maximum amount of services, and pay that same provider on a fee-for-service basis for services that are not provided within the time period or that exceed the maximum amount of services. In addition, although we may pay a provider such as a medical clinic using one type of reimbursement method, that clinic may pay its employed providers using another reimbursement method.

Check with your individual provider if you wish to know the basis on which he or she is paid.

HealthPartners Approach to Protecting Personal Information

As a health plan, HealthPartners complies with federal and state laws regarding the confidentiality of medical records and personal information about members and former members. They have developed policies and procedures to ensure that the collection, use and disclosure of such information comply with the law. Whenever necessary, HealthPartners obtains consent or authorization from members, or an approved member representative when the member is unable to give consent or authorization, for disclosure of personal information.

HealthPartners gives members access to their own information consistent with applicable law and standards. HealthPartners policies and practices are designed to facilitate appropriate and effective use of information, internally and externally, to enable them to serve members and improve the health of their members, patients, and the community, while being sensitive to their privacy. If you would like to receive a copy of HealthPartners privacy notice, please visit healthpartners.com or call Member Services at 952-883-5000 or 800-883-2177. For your provider's privacy policy, please contact your provider directly.

Take Your HealthPartners Coverage Wherever You Go

If you're planning to travel outside Minnesota, HealthPartners will travel with you. All HealthPartners members who travel outside of Minnesota have access to the extensive Open Access network in alliance with CIGNA HealthCare network of health care providers. The network consists of more than 950,000 doctors and other care providers and 6,000 hospitals across the country, all of which have met CIGNA provider-credentialing standards.

Aside from the HealthPartners Open Access Choice with Deductible Plan, out-of-network benefits apply when a HealthPartners member receives services from a CIGNA provider. However, the member's portion of the bill is based off a discounted amount, resulting in lower out-of-pocket costs. HealthPartners member identification cards (ID cards) identify that the CIGNA providers are available out-of-network. In the HealthPartners Open Access Choice with Deductible Plan, services received from a CIGNA provider are covered at the in-network level.

For information about CIGNA providers, members can access the HealthPartners website at healthpartners.com or call Member Services at 952-883-5000 or 800-883-2177. Look for the CIGNA number on the back of your member ID card. Please note that the CIGNA network arrangement does not change your health plan's benefits; please see your Group Membership Contract for benefit details.

Claim Forms

When you receive health services from a HealthPartners network provider, the provider submits the claim for you. When you receive health services from out-of-network providers, you must complete a claim form and submit it to HealthPartners for reimbursement. Details regarding reimbursement are described in the Group Membership Contracts. You can request additional claim forms from HealthPartners Member Services at 952-883-5000 or 800-883-2177.

Prior Authorization Through CareCheck

The CareCheck program is a precertification and utilization management program for members using out-of-network providers for hospitalization services. To assure that you receive cost-effective, medically appropriate care when using an out-of-network provider, you must notify HealthPartners in advance whenever hospitalization or surgery is arranged. HealthPartners staff will evaluate and advise you of the medical necessity of the hospitalization or surgery; the extent of benefit coverage you can expect; and care alternatives that may maximize your benefits.

If you are hospitalized or require surgery out-of-network and do not call CareCheck for prior authorization, benefits will be reduced. Please check your Group Membership Contract for more information about prior authorization through the CareCheck program. If you are using a HealthPartners network provider, it is not necessary to call CareCheck.

You can call CareCheck 24 hours a day. For members living in the metro area, the number is 952-883-5800. Members living outside the metro area call toll-free at 800-942-4872.

Dental Coverage

The HealthPartners medical plan covers preventive dental visits with dentists in the HealthPartners Network. This benefit is available for all members on the health insurance plan. There is no copay required for preventive dental services – coverage is 100 percent. Preventive dental services include:

- ◆ Examination of mouth and teeth
- ◆ Cleaning and polishing of teeth
- ◆ Oral hygiene instructions
- ◆ Professionally applied fluoride treatments
- ◆ X-rays

You can find a list of dentists participating in the HealthPartners network online at healthpartners.com and in the HealthPartners Dental Network directory.

In addition to this benefit, the HealthPartners Dental Distinctions optional dental plan is available to employees. Please see additional information about this plan on [page 61](#).

Member Phone Support CareLineSM Nurse Line

The HealthPartners CareLine Nurse Line is a free phone service staffed by specially trained nurses to answer members' health questions. CareLine nurses assess the caller's condition and discuss the most appropriate care options – whether it's an emergency room, urgent care visit or self-care at home. Members find it reassuring to have an expert to call who can advise them. CareLine is available 24 hours a day, seven days a week, 365 days of the year. Call 612-339-3663 or 800-551-0859. If you're hearing impaired, call 952-883-5474.

HealthPartners Nurse NavigatorsSM Program

For more complex health issues, HealthPartners skilled Nurse Navigators can help members sort through care, benefits and provider issues. They also guide members to important services and information that can help them get the most from their treatment and coverage. Nurse Navigators are available through Member Services.

BabyLine Phone Service

The HealthPartners BabyLine Phone Service is a special phone line that provides support for expectant parents and new parents up to six weeks postpartum. Call 800-845-9297 to speak with ObGyn nurses about pregnancy, new baby care, nursing and postpartum issues.

Behavioral Health Navigators

You may need help in recognizing behavioral health needs or finding the appropriate provider. Call 888-638-8787 to be matched with the network provider who best meets your behavioral health needs. Providers can be identified based on:

- ◆ Specialty or subspecialty
- ◆ Specific diagnostic, language and cultural competence

If you have an urgent need, staff can link you to same day/next day psychiatric appointments.

Member Services

HealthPartners Member Services representatives are ready to answer your questions about HealthPartners plans and providers. These trained staff members can answer administrative questions and help with inquiries about benefits, claims and more. The Member Services number is 952-883-5000, or toll-free 800-883-2177. People with a hearing impairment may call 952-883-5127. Member Services representatives are available to assist you Monday through Friday from 7 a.m. to 7 p.m., CT.

HealthPartners has expanded Member Services offerings to include face-to-face support, online chat, extended hours by appointment; internet access through secure web mail; the ability to work with the same Member Services representative each time help is needed; and specially trained Nurse Navigators who can explain medical terminology, coverage and care guidelines.

If you have an inquiry or concern, you should call HealthPartners Member Services at 952-883-5000 or 800-883-2177. A Member Services representative will work with you to respond to questions and attempt to resolve any concerns or complaints. If a mutually agreeable resolution cannot be reached and you wish to pursue the issue further, you may file an appeal.

If you want to appeal a decision made by HealthPartners, you must notify the Member Services Department in writing. Member Services will provide you with detailed information on how you may pursue the appeals process. Additional appeal information can be found at healthpartners.com.

Website

You have a secure, personal website at healthpartners.com. Through your myHealthPartners account, you have instant access to detailed information and helpful services tailored to you. Depending on your specific coverage, you may:

- ◆ View your medical provider network
- ◆ View your benefits
- ◆ Order new Member ID cards
- ◆ View claims status and/or history and explanation of benefits
- ◆ Refill mail order medications and prescriptions at HealthPartners pharmacies
- ◆ Schedule an appointment at a HealthPartners Clinic
- ◆ Apply to enroll in condition management programs
- ◆ Contact member services with questions and concerns
- ◆ Use the virtual coaching feature to get on the path to a healthy lifestyle
- ◆ Use the My Health Diary to establish a personal health record to manage health-related activities
- ◆ Receive confidential medical information from HealthPartners in a secure mailbox
- ◆ Get test results, schedule a doctor's appointment, email your care team, pay your bill, request an appointment from a specialist or look up immunization records for you or a family member under the age of 13.

HealthPartners Clinics offer the only **online appointment scheduling service** in the Twin Cities that allows patients to select their provider of choice, appointment time and date, and actually book their HealthPartners Clinic appointment online directly through healthpartners.com.

Mobile Tools

Download the *myHealthPartners* phone app or visit the mobile site to find and manage your health plan on-the-go.

Use your smartphone to:

- ◆ Access your Member ID card
- ◆ Check your plan balances including your deductible
- ◆ Search for the closest care locations to you

Download the app today in the iTunes app store or visit my.healthpartners.com. To learn more about HealthPartners mobile offerings, visit healthpartners.com/gomobile.

If you have a mobile phone that can get text messages, you can receive a variety of texts from HealthPartners. Either opt in to receive weekly texts or add a phone number in your myHealthPartners account to get texts specific to you.

Text one of these commands to 77199:

- ◆ **DED:** For how much is remaining until you meet your deductible
- ◆ **YUM:** For better-for-you eating tips from yumPower
- ◆ **FAMILY:** For ideas to support your family's health
- ◆ **QUITNOW:** For tips to help you quit smoking

Cost Estimate

Know what to expect in your doctor's bill and get peace of mind with a cost estimate. Search for a treatment or procedure, and get estimates specific to your plan, benefits and deductible. Cost estimates are available for nearly 300 treatments and procedures including:

- ◆ Biopsies
- ◆ CT scans, X-rays and MRIs
- ◆ Delivering a baby
- ◆ Physical therapy
- ◆ Joint replacements

Coverage Policies

As part of HealthPartners commitment to “no secrets, no surprises” for members, HealthPartners publishes the coverage guidelines that let members know in advance if a particular service is covered.

HealthPartners Formulary

You can quickly and easily see all of the medications on the HealthPartners formulary. You can search by drug name (either brand or generic) or by type of drug (e.g., antibiotics).

Clinic and Provider Information

<p>Clinic Information</p> <ul style="list-style-type: none"> ◆ Clinic hours ◆ Locations, including directions ◆ Providers ◆ Hospitals and key specialists ◆ Open/closed to new patients 	<p>Comparative Data</p> <ul style="list-style-type: none"> ◆ Quality of care measures ◆ Consumer satisfaction survey results
<p>Provider Information</p> <ul style="list-style-type: none"> ◆ Practice specialty ◆ Credentials ◆ Personal profiles (some even include photos) 	<p>Plan Information</p> <ul style="list-style-type: none"> ◆ Plan-wide programs and services including member discounts, health improvement programs and health education classes ◆ Member information, including member handbooks, consumer rights and quality improvement

As always, the HealthPartners website will help you make informed decisions about clinics and providers.

EMPLOYEE ASSISTANCE PROGRAM

Since personal, legal and financial problems can decrease on-the-job productivity, HealthPartners provides a telephonic and online Employee Assistance Program (EAP). HealthPartners EAP is a confidential assessment, counseling and referral service to help you resolve personal or work-related problems including relationships, mental health, legal troubles, domestic issues, substance abuse, gambling, financial concerns or work concerns. It's available online at hpeap.com (Password: saintpaul) or by phone for employees and their families at no cost, 24 hours a day, seven days a week. Professional counselors are a toll-free phone call away at 866-326-7194 or 800-827-3707 for the hearing impaired.

If you want to talk to a counselor in person, just call the toll-free phone number and you will be connected with an EAP professional. You can meet with a counselor for up to three free visits per issue.

In addition, HealthPartners EAP offers culturally diverse services. For example, callers may speak with Spanish-speaking counselors, and website content is available in English and Spanish.

HealthPartners EAP also offers assistance for managers and supervisors to get information and support for dealing with personnel concerns. HealthPartners EAP complements the City's internal resolution processes with an objective third-party perspective – without replacing or infringing upon personnel policies or procedures.

HEALTHY SAINT PAUL



Healthy Saint Paul

The new Healthy Saint Paul Well-Being Program begins January 1, 2016 and ends September 30, 2016. This year's program has been revised. Below is a summary of the components. You can find all the details on www.healthy.stpaul.gov.

Online health assessment.

In just 15 minutes, you can check out how healthy you are by completing the online health assessment at www.healthpartners.com/wellbeing. Knowing is the first step to changing. It's quick, easy and confidential. Your results will help you understand how you can get healthy and feel great.

Biometric Screening

Do you know what your cholesterol levels are – or if they're in the healthy range? How about your blood pressure or glucose? These are all important numbers for you to know. Knowing your numbers puts you in control of your health. Here's what will be checked during your health screening:

- Blood pressure measures the pressure your blood puts against the walls of your arteries as your heart pumps blood through your body
- Cholesterol is a type of fat that helps build cells
- Glucose is a type of sugar found in your blood that your body uses for energy
- Height and weight gives you your Body Mass Index (BMI)

Complete your biometric screening one of two simple ways – it's your choice.

1. Want to get screened while you're at work?

- ✓ Attend a screening event at your worksite in January.
- ✓ In December 2015, you will be able to make an appointment. Watch for additional information and instructions.
- ✓ Screenings will be held at several City of Saint Paul locations.
- ✓ Following your screening, you will meet with a health professional who will review your results with you and answer any questions.

2. Visited your doctor recently or will you be soon?

- ✓ Submit the signed Biometric Screening Fax Form. The form can be downloaded from www.healthy.stpaul.gov.
- ✓ Results can be taken from numbers measured by your doctor from March 1, 2015, through February 28, 2016. Include all four measures listed on the Biometric Screening Fax Form. All forms must be received by February 28, 2016.

Health Coaching

A health coach provides support, guidance and assistance towards reaching your goal, whatever that may be.

1. Call HealthPartners to speak to an Engagement Specialist. The Specialist will assist you in determining where you would like to focus your attention and schedule your first call. To sign up with a health coach, please call 952-883-7800, 800-311-1052 (toll-free) or the TTY lines at 952-883-7498 or 877-222-2794 (toll-free).
2. Complete three coaching calls.

To find out all the details of the Healthy Saint Paul Well-being program and more, visit www.healthy.stpaul.gov . While there, you can also sign up to receive the latest updates via email.

Please note that you must complete these components by the deadline (February 28, 2016 for biometrics and September 30, 2016 for health assessment and phone coaching) to receive the health incentive defined in your bargaining unit contract.

**CAFETERIA PLAN
&
FLEXIBLE SPENDING ACCOUNTS**

CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNTS

Important: You can now submit your claims on-line through the Participant Portal! See the “how to” instructions later in this section.

PLAN OVERVIEW

The City of Saint Paul cafeteria plan allows eligible employees to save tax dollars by contributing to the qualified plans with pre-tax dollars; thereby reducing taxes and increasing take home pay.

If you are benefit eligible, you can set aside between \$120 and \$2,500 each year for payment of certain health care expenses and up to \$5,000 (total for both husband and wife) each year for payment of certain dependent care expenses (daycare). Pre-tax payroll deductions and contributions to these accounts are not subject to federal, state, or social security taxes.

A summary of the cafeteria plan and flexible spending account features are on the following pages. The formal plan document controls the operation of the plan in all circumstances. A Summary Plan Description is available on the Knowledge Base in BenefitReady and on the City of Saint Paul web site at:

<http://www.stpaul.gov/benefits>

FSA Administrator

CieloStar administers the flexible spending accounts for the City of Saint Paul.

Effective Dates

The cafeteria plan and flexible spending accounts became effective January 1, 1989. The accounts operate on a “plan year” that always ends on December 31. A new plan year will begin on January 1 and will run through December 31. You must enroll during the annual open enrollment, prior to the beginning of each plan year, for benefits and expenses that will be incurred during the plan year or period of coverage.

Eligibility

All employees of the City of Saint Paul who have met the eligibility requirements for the City-sponsored insurance plan may participate as of their effective date.

For subsequent plan year enrollments, an employee must be actively at work on the first day of the plan year. If the employee is not actively at work on January 1, participation will be delayed until the employee is actively at work.

If you do not enroll when you are first eligible, federal regulations require that you wait until the following plan year (January 1) to participate. However, some qualifying events may allow you to make an election change. All changes must be consistent with the event as required by the IRS, and

Employee Benefits must be notified within 30 days of the qualifying event. The following events would permit a mid-year change to your health, dental insurance plan, and/or your flexible spending account election:

- ◆ Change in marital status (marriage/divorce/legal separation/annulment)
- ◆ Change in number of dependents (birth/adoption/death)
- ◆ Employment status change for you, your spouse, or your dependent
- ◆ Dependent eligibility (attainment of plan maximum age /new or loss of group coverage).

The above examples are not comprehensive. If you have a question regarding status changes, please contact Employee Benefits at (651) 266-6498.

In addition, you must re-enroll during the annual open enrollment for each subsequent plan year in which you wish to participate. Your current elections do not carry forward to future plan years. An election to participate is valid for only one plan year (January 1 – December 31).

Accounts Available

There are three ways in which you can save money with the City of Saint Paul cafeteria plan:

- ◆ **Pre-Tax Premiums:** When you are eligible and enroll in the City-sponsored health and/or dental plan, the premium costs that you are responsible for will be deducted from your paycheck before taxes are taken out.
- ◆ **Health Care Account:** When you enroll in this account, you must decide how many of your payroll dollars (between minimum of \$120 and maximum of \$2,500 annually) for the plan year will be directed to this account to pay, on a pre-tax basis, for eligible health care expenses that would otherwise be paid out of your pocket on an after-tax basis. Examples of expenses that are eligible are listed on [page 37](#).
- ◆ **Dependent Care Account:** When you enroll in this account, you decide how many of your payroll dollars (not to exceed \$5000 annually) will go into this account to pay, on a pre-tax basis, for eligible dependent care (daycare) expenses while you are at work and your spouse is at work/school/seeking work. See [page 42](#) for more information.

Amounts deposited in one account cannot be used to reimburse expenses from the other accounts; money cannot be commingled. The funds you elect to contribute to the health care account and dependent (daycare) care account will be set aside pro-rata from 24 of your paychecks each year (the first two paychecks per month)

Administrative Fee

No administrative fees will be charged to employees who participate in the health care account and/or dependent care account.

Enrollment Procedures

Elect participation in all Flexible Spending Accounts using the BenefitReady system. CieloStar representatives will be available at open enrollment information sessions to assist you with any questions.

Forfeitures

According to federal law, any funds remaining in your health care and dependent care accounts after the payment of eligible expenses incurred during a plan year will be forfeited. You must submit any reimbursement requests for expenses incurred through your period of coverage for the prior year in order to be reimbursed from the prior year's contributions. **Reimbursement requests for medical and daycare must be received at CieloStar by February 15, 2017, 4:30 PM CT, for eligible expenses incurred during the 2016 plan year.**

Budgeting your accounts carefully should help you to avoid forfeitures. Even if you do incur forfeiture, you still may be money ahead. For example, if you would otherwise pay a total of 30% in federal, state, and social security taxes, you could save 30% on any expenses you pay with pre-tax dollars through these accounts. Therefore, if you deposit \$1,000 into your account and you forfeit \$100, you're still \$200 ahead because you've saved approximately \$300 in taxes.

Disclaimer

If you have questions regarding the eligibility of a particular expense, resources that can be of assistance are IRS publications 502 and 503 (for health care and dependent care expenses, respectively) which are accessible through the IRS website at www.irs.gov, the library, or your tax advisor.

Please note that CieloStar and the City do not provide tax advice to participants. Provisions for the health care, dependent care and transportation accounts make every attempt to follow the same rules used by the IRS with respect to health care, dependent care, and transportation expenses. Unfortunately, some types of expenses are not clearly identified by the IRS and, in those instances, you should check with the above resources before you enroll in these accounts to determine if your particular expense will be reimbursable.

The City of Saint Paul can make no guarantee that the provisions of these accounts will not be changed due to federal or state laws, or that they will not be amended or withdrawn at some future date.

Estimated Impact on Social Security

Your social security benefits could be affected if your taxable earnings are less than the social security maximum covered wages (\$118,500 in 2016). The laws affecting social security taxes and benefits are constantly changing, so there is really no way to predict how you may be affected. The decision becomes one of whether the current overall tax savings are more valuable to you than a possible reduction in social security benefits in the future.

Impact on PERA and Other Benefits

Your PERA contributions and benefits will continue to be based on your gross pay (total wages) before deductions, so they would not be reduced if you participate in the cafeteria plan or flexible spending accounts. In addition, benefits from other City pay-related benefit plans are based on your gross pay without regard to any salary conversion amounts.

If your spouse's employer offers a Health Savings Account (HSA) you are probably ineligible for an FSA. If you have further questions, please contact Employee Benefits at (651) 266-6498.

Tax Savings

The chart illustrates possible tax savings using a flexible spending account. These are estimates only for demonstration purposes. To calculate your exact tax savings, please contact a tax advisor.

Example of Healthcare FSA Savings

	Using After-Tax Dollars	Using Pre-Tax Dollars
Your Income	\$36,000.00	\$36,000.00
(Less) Total family co-pays		\$80.00
(Less) Dental co-insurance		\$520.00
(Less) Contact lenses		\$100.00
(Less) RX and OTC meds		\$300.00
(Less) Child's braces		\$2,000.00
Taxable Income	\$36,000.00	\$33,000.00
(Less) Estimated federal, state, and social security taxes	\$9,021.22	\$7,970.57
Income After Taxes	\$26,978.78	\$25,029.43
(Less) Total family co-pays	\$80.00	
(Less) Dental co-insurance	\$520.00	
(Less) Contact lenses	\$100.00	
(Less) RX and OTC meds	\$300.00	
(Less) Child's braces	\$2,000.00	
TAKE HOME PAY	\$23,978.78	\$25,029.43

Example of Dependent Care Savings

	Using After-Tax Dollars	Using Pre-Tax Dollars
Your Income	\$36,000.00	\$36,000.00
(Less) Day care expenses		\$3,600.00
(Less) Summer camp expenses		\$1,400.00
Taxable Income	\$36,000.00	\$31,000.00
(Less) Estimated federal, state, and social security taxes		7,487.51
Income After Taxes	\$26,978.78	23,512.49
(Less) Day care expenses	\$3,600.00	
(Less) Summer camp expenses	\$1,400.00	
TAKE HOME PAY	\$21,978.78	\$23,512.49

ONLINE FLEXIBLE SPENDING CLAIM SUBMISSION

ONLINE FSA CLAIM SUBMISSION

EASILY SUBMIT A FLEXIBLE SPENDING CLAIM ELECTRONICALLY FROM THE
CONVENIENCE OF YOUR HOME USING YOUR COMPUTER.

HERE'S HOW:

- ✓ Log into your flexible spending account in BenefitReady, click on Benefits, HRA or FSA, then click on the blue link.

Log into your [Participant Portal](#).

Under the My Accounts tab in the left hand column, Select REQUEST REIMBURSEMENT

- ✓ Select ADD NEW

Add claim information in the Add/Edit Claim window and be sure to attach any appropriate documentation if necessary. When finished, select OK

Verify your claim information. If you need to make any changes, click on EDIT to make any necessary changes.

Check the CERTIFICATION Box and then select SUBMIT

- ✓ To print a copy of the claim you submitted, select the VIEW RECEIPT SUBMITTAL FORM.

CONGRATULATIONS, YOUR CLAIM HAS BEEN SUBMITTED!

- ✓ To review your claim, select VIEW CLAIMS PENDING
- ✓ Select SUBMITTED CLAIM in the drop down menu.

ONLINE CLAIM SUBMISSION FAQ

Am I using a secure site?

Yes, Participant Portal is a secure site.

Does it take longer to receive my reimbursement if I use online claim submission?

No, your claim will be processed on normal processing days.

What documentation do I need to provide with my claim reimbursement request form?

Proper documentation includes itemized receipts, explanation of benefits or a statement from your provider. All documentation should include the date of service or date of purchase, service provided or items purchased and amount of expense. A voided check is not considered proper documentation. Required documentation is the same regardless of method used to submit claim.

What type of file can my receipts be in?

PDF, .JPG, .JPEG, .GIF, .PNG, .TIFF, .TIF, .XLS, .XLSX, .DOC, .DOCX

Does my receipt file have a size limitation?

Yes, 1MB or smaller

Will I be notified if I made an error in my submission?

Yes, you will be notified either by e-mail or letter.

If I received my reimbursement via direct deposit previously will I receive my online claim payment this way?

Yes, submitting online claims does not change your current reimbursement method.

How do I know my claim has been received?

You will see your online claim listed in your claims history.

I submitted an online claim for reimbursement, but I haven't received my reimbursement yet. What should I do?

Log into WealthCareAdmin.com and click on Transaction History to see the claim payment date or if the claim was denied. If you do not see the claim you're looking for, select View Claims Pending to see if it is still in the queue to be processed. Use the down arrow in the View field to select Submitted Claims. If you have any questions regarding your claim please contact the CieloStar Flexible Spending Department at 1-877-491-5979

Can I contact someone if I have questions on how to submit my online claim?

Please contact the CieloStar Flexible Spending Department at 1-877-491-5979 if you have questions regarding online submissions.

HEALTH CARE ACCOUNT

Qualifying Expenses

Health care account expenses that qualify for pre-tax reimbursement are any medical or medically-related expense including over-the-counter drugs, if they are accompanied by a physician's prescription. You can elect a minimum of \$120 to a maximum of \$2,500 per plan year. This includes eligible expenses for you and your family that are not taken as a deduction on your income tax form, and **only** if you are **not** reimbursed for the expense from any other source. Premiums for insurance are not eligible for pre-tax reimbursement under this account. Cosmetic surgery and other elective procedures are not reimbursable under this account unless medically necessary to correct a congenital abnormality or a deformity arising from injury or accident.

Some examples of expenses that can be paid on a pre-tax basis from your health care account are:

- ◆ Dental, mental health, or chemical dependency co-payments
- ◆ Chiropractic services
- ◆ Prescription drugs (including co-payments)
- ◆ Mental health services
- ◆ Dental expenses (non-cosmetic)
- ◆ Orthodontia (Special rules apply. See next page)
- ◆ Medical equipment
- ◆ Smoking cessation programs
- ◆ Assistance for persons with disabilities
- ◆ Over-the-counter drugs to treat illness, injury, or disease, prescribed by your physician
- ◆ Vision care, prescription eye glasses, contact lenses, contact lens solution, or laser surgery
- ◆ Chemical dependency services
- ◆ Ambulance service
- ◆ Medically-related transportation
- ◆ Nursing care
- ◆ Hearing aids
- ◆ Psychiatric care (excludes group/marriage counseling)
- ◆ Deductibles, co-payments, and co-insurance from your health insurance plan
- ◆ Insulin pump and diabetic supplies

IRS regulations govern the eligibility of expenses, including those not fully covered by a health care plan and prescribed by a physician or other licensed professional primarily for the purpose of preventing, treating, or mitigating a defect or illness. IRS Publication 502 contains guidance on eligible and ineligible medical, vision, or dental expenses that may be claimed on your Individual Income Tax. Most of the information contained in IRS Publication 502 may apply to reimbursement regulations for your Flexible Spending Account. CieloStar can assist you in determining whether a specific expense is reimbursable. You should always confirm that any contemplated medical expenses are reimbursable before you sign up for this account.

ORTHODONTIA EXPENSES

And Flexible Spending Account Reimbursement

Orthodontia is a covered medical expense, but it can be tricky because of the extended nature of the treatment and the manner in which fees are paid. We strongly encourage any participant with questions to call CieloStar before beginning treatment at 877-491-5979.

The basic Internal Revenue Service rules for reimbursement of eligible expenses through a Flexible Spending Account state:

- 1) An individual may only be reimbursed for expenses incurred while a participant is in the plan.
- 2) An expense is incurred when the service is performed (not when it is billed or paid).
- 3) The participant must submit documentation showing that the expense has been incurred (service has been provided).
- 4) The expense must be reimbursed from funds allocated for the plan year in which the expense was incurred. Expenses or unused funds cannot be carried over to a different plan year.

Orthodontic treatment is usually provided over an extended period of time, with an initial examination and installation, and monthly adjustments. The services are often paid for over an extended period of time, with an initial down payment, and monthly payments over the life of the contract.

There have been extensive conversations with the IRS on how orthodontic expenses are to be reimbursed. Their basic rule still applies in that expenses may only be reimbursed after they have been incurred, which means after the actual service has been provided. They have stipulated, however, that if the orthodontia fee payment schedule is a reasonable approximation, in both time and dollars, of the actual costs and services provided over the duration of treatment, then we may reimburse for the initial down payment and for the monthly charges as each payment is made according to the fee schedule. The participant, therefore, has two ways to submit documentation in order to be reimbursed, either on a "services provided" basis or on a "fee payment schedule" basis.

The first method is the same as any other medical expense and requires the participant to submit a statement from the orthodontist showing that a service has been provided and stating the cost of that service.

The second method allows the participant to submit proof that payment has been made at the required time called for by the payment schedule. The participant **MUST** submit a treatment plan from the orthodontist, including the total cost of the treatment, the expected length of the treatment, the down payment amount, and the monthly fee to be reimbursed. For example, suppose the total cost of treatment is \$3000, is expected to last 24 months, and the contract calls for a down payment of \$600 and a monthly charge of \$100 for 24 months. We will reimburse the \$600 upon receipt of documentation showing that the initial service has been provided and payment has been made. We will reimburse \$100 per month upon receipt of documentation showing that the monthly payment has been made. This documentation could either be a receipt from the orthodontist showing that payment has been received for the current month's scheduled charge, or a photocopy of the current month's payment coupon and the participant's personal check.

Notes:

- You cannot pre-pay for services and be reimbursed at the time of that payment. You can only be reimbursed as services are provided. If a total payment is made up front for the treatment, the participant still must submit a treatment plan and the payments will be disbursed over the course of the length of treatment. Down payments for orthodontia are reimbursed at 20%.
- If you decide to pay off the contract early while the treatment is still continuing you can only be reimbursed as services are provided.
- If the treatment is completed sooner than expected and you decide to pay off the remainder of the contract early you can be reimbursed for that payment because the services are complete.

Why does the IRS make these rules regarding payment of orthodontic claims?

The IRS is actually protecting the employer group by placing these guidelines on orthodontic claims. For example, an employee elects \$2500 for medical flex for 2016 and is paid out the entire \$2500 for his/her child's orthodontia in February of 2016. The employee leaves the company on March 1, 2016. The employer group is responsible for the \$2500 even though the employee did not have \$2500 deducted from their paycheck. The orthodontic services have not really been rendered yet, so the employer group is paying for orthodontic services that will be rendered after the employee has left the company. Although medical flex always poses a risk for employer groups, orthodontia is unique in that the services are rendered over a period of time. Most other medical or dental expenses are incurred at the time of the expense and less of a risk of paying for expenses that are incurred after an employee terminates, or in a plan year that the employee does not elect a flexible spending account.

Reimbursement for Health Care Expenses

When you incur an eligible health care expense and either submit the claim or use your Benefits Debit Card, the plan will pay the lesser of:

- ◆ The amount of the expense you are submitting; or
- ◆ The total amount you have elected to contribute to the plan for the year, reduced by any previous claims you have made during the plan year.

Expenses incurred during one year cannot be reimbursed with money contributed in a prior or subsequent year, nor can expenses incurred prior to the inception of the health care account be paid. Only the eligible expenses you incurred while you were a participant in the health care account can be reimbursed with pre-tax dollars you contributed. Reimbursements are eligible based on when services are incurred, not when you pay for services (this applies to orthodontic; see previous page for information on Orthodontia. All requests for reimbursement for expenses incurred in a plan year must be submitted by February 15, 2017 4:30 PM CT following the end of the plan year.

Qualifying Status Changes

The plan provides that a change to your election may be allowed mid-plan year under certain circumstances in which the family's status has been affected. All changes must be reported to employee Benefits within 30 days of the event. All changes must be consistent with the event as required by the IRS. The following events would allow a mid-year change to your healthcare election:

- ◆ Change in marital status (marriage/divorce)
- ◆ Change in number of employee's dependents (birth/adoption/death)
- ◆ Change in employment status of employee or employee spouse. Includes strike, lockout, termination of employment, or gaining employment.

The above examples are not comprehensive. If you have any questions regarding status changes, please contact Employee Benefits at (651) 266-6498.

Leave of Absence

Refer to pages [85-87](#) for leaves of absence.

Termination of Employment

If you terminate employment during the year, your period of coverage under the health care account will cease the end of the month in which your last day of work occurred. Expenses incurred prior to your date of cancellation can be submitted throughout the remainder of the plan year. However, expenses incurred after your date of cancellation cannot be paid from this account. You may be allowed to continue your participation in the health care account (if qualified) by electing COBRA continuation coverage through the remainder of the plan year (see [page 85](#)).

Qualified Medical Child Support Orders

In certain circumstances, you may be able to enroll a child of a participant in the plan in the medical expense reimbursement portion of the plan by filing a Qualified Medical Child Support Order (QMCSO) with the employer. A QMCSO may only be filed with respect to a child of a participant of the plan. If you are interested in more information and the procedures for filing, please contact employee Benefits at (651) 266-6498.

Tax Considerations

Generally, paying for uninsured medical and dental expenses through the health care account is more advantageous than deducting those expenses on your income tax form. Only your uninsured medical and dental expenses in excess of 7.5% of your adjusted gross income are deductible on your income tax form. However, under the health care account, all of your uninsured medical and dental expenses can be paid for with pre-tax dollars up to the limit of \$2,500. Plus, under current law, you don't pay social security tax on amounts used to pay for these expenses through your health care account. Neither CieloStar nor the City of Saint Paul is permitted to give advice about personal income tax matters. You should consult your own tax advisor to help you determine if using the pre-tax health care account is advantageous for you.

DEPENDENT CARE ACCOUNT

Qualifying Expenses

Dependent care expenses that qualify for reimbursement must be necessary in order to permit you to be gainfully employed. If you are married, your spouse must be working in a job for pay outside your home, actively seeking employment, be a full-time student, or be physically or mentally unable to care for him or herself. Expenses must be for the care of a qualifying dependent under the age of thirteen (13).

The following list outlines ALLOWABLE dependent care expenses:

- ◆ Provider caring for an individual in the employee's home
- ◆ Family daycare provider in the home of the provider (Licensed or Unlicensed)
- ◆ Daycare centers that comply with state and local laws
- ◆ Before/After school care programs
- ◆ Pre-school programs (for custodial purposes only)
- ◆ Church daycare programs
- ◆ Day Camps (for custodial purposes only)
- ◆ Sick-child facilities

The following list outlines dependent care expenses that are NOT ALLOWABLE:

- ◆ Educational expenses, including Kindergarten
- ◆ Overnight Camps
- ◆ Fees charged for field trips, meals, or activities
- ◆ Transportation expenses
- ◆ Nursing home expenses
- ◆ Care provided by employee's child who is under the age of 19 or by employee's dependent

Expenses incurred during one year cannot be reimbursed with money contributed in a prior or subsequent year, nor can expenses incurred prior to the inception of the account be paid. Only the eligible expenses you incur while you are a dependent care account participant can be reimbursed with the pre-tax dollars you contribute.

The calendar year maximum is \$5,000 in dependent care expenses for one or more dependents. If you are married, and you and your spouse file separate federal income tax returns, not more than \$2,500 of dependent care expense reimbursements for services provided during the year is exempt from tax. Any excess must be declared on your tax form as taxable income, and you must notify employee Benefits at (651) 266-6498 of the excess.

If you are married, reimbursements from your dependent care account exceeding the earnings of the lower paid spouse for the year must be reported as taxable income for that year. For example, if you receive \$3,600 of dependent care reimbursements for expenses for services provided during a year, and your spouse earned only \$3,000 that year, the \$600 excess must be declared as taxable income. You must notify the IRS as well as employee Benefits at (651) 266-6498 of any such excess.

In order to have your dependent care expenses reimbursed on a tax-exempt basis from this account, you will have to furnish the name, address, and taxpayer identification number of your provider to the IRS on your federal income tax form.

Reimbursement for Dependent Care Expenses

When you incur an eligible dependent care expense and either submit the claim or use your Benefits Debit card, the plan will pay the lesser of:

- ◆ The amount of the expense you are submitting; or
- ◆ The total amount that has been contributed to your dependent care account to date, reduced by previous claims paid from the account.

If there is not enough money in your dependent care account to pay all the expenses you have submitted during a payment period, the excess expenses will be carried forward; this is referred to as an 'on-hold' balance. You do not have to resubmit these suspended expenses for reimbursement as they will be paid from the deposits you make in subsequent periods. For income tax purposes, the statement you receive each time you get a reimbursement check will show the amount you actually received from your dependent care account for expenses incurred during the year.

Qualifying Status Changes

The plan provides that a change to your election may be allowed mid-plan year under certain circumstances in which the family's status has been affected. All changes must be reported to Employee Benefits within 30 days of the event. All changes must be consistent with the event as required by the IRS. The following events would allow a mid-year change to your election:

- ◆ Change in number of dependents (birth/adoption/death)
- ◆ Change in employment status of employee or employee spouse
- ◆ Change in Cost or Coverage.

The above examples are not comprehensive. If you have a question regarding status changes, please contact Employee Benefits at (651) 266-6498.

Leave of Absence

If you take a leave of absence and continue to receive regular pay, sick pay, or vacation pay from the City, your contribution to the dependent care account will continue to be deducted. If, during the leave of absence, you do not receive pay from the City, your participation under the plan will be treated the same as a termination of employment. Therefore, your contributions under the dependent care account will cease, but you can continue to submit claims through the end of the plan year or until your account is depleted, whichever is earlier.

When you return to work after the leave, your dependent care contributions will resume at the same level. You cannot make a new contribution election upon your return to work unless you incurred a change in family status.

Termination of Employment

If you terminate employment while participating in the dependent care account, you may continue to submit reimbursement requests for eligible expenses you incurred after termination for the remainder of the year. However, no new contributions may be made to the account.

Any amounts remaining in the account after February 15th following the end of the plan year will be forfeited.

Tax Considerations

Under current law, a tax credit is available for the same type of dependent care expenses that are eligible for reimbursement through the plan. The amount of the credit depends on the taxpayer's adjusted gross income and ranges from 20% to 35% of eligible expenses up to a specified limit. For plan years beginning on or after January 1, 2007, the limit is \$3,000 of expenses if there is one eligible dependent and \$6,000 of expenses if there are two or more single dependents. You will not be eligible to take the tax credit for any expenses reimbursed through the plan, and the maximum amount of expenses eligible for the credit will be reduced on a dollar-for-dollar basis for each dollar of dependent care reimbursements you receive under the Plan.

For example, if you have two children for whom you incur \$7,000 of dependent care expenses in 2016 and you have \$2,000 reimbursed through the plan; the maximum amount of your expenses eligible for the tax credit is \$4,000. The \$2,000 reimbursed from the Plan cannot be considered for the tax credit, reducing the \$6,000 (the maximum amount for two or more eligible dependents) to \$4,000 (\$6,000 less \$2,000). This means that even though you incurred \$7,000 of dependent care expenses, the total amount subject to a tax benefit is \$6,000, \$2,000 through the plan and \$4,000 through the tax credit. Determining whether taking the credit or reimbursement under the plan is more beneficial involves complex calculations. Because each individual's situation is different, the City cannot predict whether or not it would be more beneficial to you to take the tax credit for dependent care expenses or have your expenses reimbursed under the plan.

Dependent Care Account or Tax Credit – Which is Right For You?

Both the dependent care account and the federal dependent care tax credit are designed to save you money on your dependent care expenses by reducing your taxes. But which is the best option to choose?

Earned income is your family income from working (yours and your spouse's, if married) minus any pre-tax deductions for benefits. Generally, this is the income shown on your W-2.

Several issues help determine eligibility for earned income credit. Typically, the main issue for eligibility is if your earned income is low enough to qualify.

Pre-tax contributions you make for health care coverage, employee savings plans, and flexible spending accounts help reduce your earned income. Making these pre-tax contributions may help you qualify for the earned income tax credit. You may want to consult your tax advisor for further assistance, especially for factoring in any impact on state income taxes.

TRANSPORTATION ACCOUNT

Qualifying Expenses

This transportation plan will allow you to pay for your eligible parking expenses on a pre-tax basis, thereby reducing your taxable income.

This plan is regulated under Internal Revenue Code Section 132(f). The Code sets monthly maximums for reimbursement. Parking expenses cannot exceed \$250 each month.

Reimbursement for Transportation Expenses

When you incur an eligible transportation expense and either submit the claim or use the Benefits Debit Card, the plan will pay the lesser of:

- ◆ The amount of the expense you are submitting; or
- ◆ The total amount that has been contributed to your transportation account to date, reduced by previous claims paid from the account. Not to exceed maximum monthly election.

If there is not enough money in your transportation account to pay all the expenses you have submitted during a pay period, the excess expenses will be carried forward (to the end of the month), this is referred to as an 'on-hold' balance. You do not have to resubmit these suspended expenses for reimbursement as they will be paid from the deposits you make in subsequent periods, not to exceed the monthly maximum allowed (the lesser of the amount contributed in a month or \$250). For income tax purposes, the statement you receive each time you get a reimbursement check will show the amount you actually received from your transportation account for expenses incurred during the year.

A reimbursement claim form must be completed and signed, accompanied with the original or photocopy of the qualified transportation expense (i.e., parking invoice, parking receipt, etc.). A claim form may be printed from the Knowledge Base on the BenefitReady system. In the event that a receipt or invoice is not available due to metered parking, unattended contract parking, or automated charge to a credit card, *Self-Certification* may be accepted. Self-Certification simply requires the participant to complete and sign the necessary reimbursement request form.

Forfeitures

Reimbursement requests must be received by CieloStar by January 30, 2016 4:30 PM CT, for transportation expenses incurred in the 2015 plan year. Remaining balances will be rolled over to the 2016 plan year providing you enroll in the transportation flexible spending account for 2016. This deadline is not the same as the Medical or Dependent Care deadline. (See the run-out schedule on page 50.)

Termination of Employment

If you terminate employment while participating in the transportation account, you may continue to submit reimbursement requests for eligible expenses but only for claims incurred before you stopped working. Any amounts elected but not used, including amounts carried over from prior months, and remaining in the account after January 30 will be forfeited unless you have elected to participate in the transportation account for the following plan year.

FAQs

Q. Who is eligible to participate in the plan?

A. Eligible employees include all benefit eligible employees of the City of Saint Paul working in a DOWNTOWN location. Employees of the Griffin Building & ECC are not eligible to participate in the parking plan.

Q. When may I begin to participate in the plan?

A. You may begin participation in the plan thirty (30) days after your date of hire or any month thereafter in which you begin to incur parking expenses. Employees enrolling during the annual enrollment will begin participation January 1 of the new plan year.

Q. When may I begin submitting expenses for reimbursement?

A. You may begin submitting requests for reimbursement of expenses incurred after the date you become eligible for and enroll in the plan. Payments will be made on a regular basis. Claims are paid based on actual contribution. You may choose to receive a check in the mail or you may want to sign up for automatic direct deposit to your checking or savings account. You may also use your Benefits Debit Card where accepted.

Q. Can I submit expenses that exceed the maximum allowable per month?

A. Yes. However, you will only be reimbursed the amount you elected or the maximum monthly allowance, whichever is lower. For example, if you pay \$260 for parking expenses in one month, you will be reimbursed for up to \$250 if elected. The additional \$10 will not be available to be reimbursed as the maximum allowable per month is \$250.

Q. What if my expenses are less than the amount I have elected?

A. Amounts elected but not used will be carried forward and may be used for qualified transportation expenses in future months. For example, if you elected \$120/month because that is your typical monthly cost for parking, but this month you only incur \$100 in parking expenses because you were on vacation, you would be reimbursed the \$100, and the \$20 balance would be carried forward. Note that regardless of the amount rolled forward, the monthly reimbursement maximum cannot exceed \$250 for parking.

Q. Would my claim ever be denied for payment? Why?

A. Yes. If your Transportation Reimbursement Claim Form has information missing it will be denied. You must sign the claim form, without your signature the form will be denied. Submit an original or photocopy invoice (copies will only be accepted if the receipt has a full date listed, i.e. July 15, 2016), or receipt with your claim form. If a receipt for your transportation expense is not provided in the ordinary course of business, the claim may be submitted without a receipt, thereby self-certifying.

Q. What is “Self-Certification” of transportation services?

A. If a receipt or invoice is not available to substantiate requested expenses, the regulation provides a participant with the ability to “self-certify”, which simply requires you to sign the claim form when a receipt or invoice is not available, such as metered parking. Be advised that by “self-certifying” your claim you are legally certifying this expense to the IRS.

Q. Once I have made an election may I change it?

A. Elections can be changed monthly. Initial and annual enrollment must be done on the BenefitReady system. Contact Employee Benefits to request monthly election changes.

Q. May I terminate participation in the plan?

A. Yes, on a monthly basis. Contact Employee Benefits at (651) 266-6498. Only amounts deducted and expenses incurred on or before your termination date will be eligible for reimbursement, however. When you terminate participation in the plan, any funds left in your account (either unused or unclaimed) after the plan close date of January 30 will be forfeited.

Q. Can I retain all of my receipts throughout the year and submit them all at the end of the year?

A. Yes. However, the plan was designed to benefit participants with the tax savings throughout the year. A recommendation would be to submit expenses throughout the year as you incur them. By waiting until the end of the year you also risk losing your receipts. REMEMBER: No more than the monthly maximum may be reimbursed for any given month.

Q. Is there a final deadline to submit prior year's claims?

A. You have until January 30, 4:30 PM CT of the next year to submit prior year claims. After January 30, any unused or unclaimed contributions shall be carried over into the following plan year providing you elected to continue participation. For example, on December 31, 2015, you have \$200 left in your transportation account. You submit your December parking claim on January 31, 2016 for \$100. On February 1, \$100 from your 2015 transportation account will be added to your 2016 transportation account to be used for expenses incurred in 2016. If you did not elect to participate for the following plan year, unused or unclaimed funds will be forfeited. **Note that the final deadline date for your transportation account is NOT the same as the final deadline date for your healthcare or dependent care account.**

Q. Does it cost me anything to participate?

A. No. You can only save dollars by participating in this plan as long as you remain an employee.

Q. Can I submit expenses after I have terminated employment?

A. Yes, but only for claims incurred before you stopped working and those claims must be submitted by January 30, 4:30 PM CT of the next plan year. Any amounts elected but not used, including amounts carried over from prior months, must be forfeited so plan carefully.

Q. Can I also claim transportation expenses my spouse incurs?

A. No, only expenses incurred by the participant (employee) are eligible for reimbursement.

Q. I carpool to work with someone. We park in a parking ramp contracted monthly. Can we each get reimbursed for half the cost of the parking spot?

A. No. The only person eligible to receive pre-tax reimbursement for the cost of the contracted parking spot is the prime member of the parking contract.

Q. May the City of Saint Paul amend or terminate the plan?

A. The City of Saint Paul has the right at any time and from time to time, by resolution of employee Benefits, or such other persons to whom such authority has been delegated, to amend the Plan. The City of Saint Paul expects the Plan to be permanent, but necessarily must, and hereby does, reserve the right to terminate the Plan at any time.

Q. How do I receive reimbursement for these expenses?

A. A Reimbursement check and/or an Advice of Deposit will be sent to your home address. Be sure to keep your payroll specialist informed of any address changes. With each check you will receive an account summary that will list the reimbursement expenses paid and any deferred (suspended) amounts. You may also use your Benefits Debit Card where accepted.

Q. How do I file a claim?

A. You must complete a reimbursement claim form. Claim forms are available to be printed from the Knowledge Base on the BenefitReady system. Make sure to include all information requested on the form, sign it, and submit the claim form along with documentation to substantiate the expense to CieloStar. Claims can also be submitted on-line.

Mail or fax your completed claim form to the plan administrator, CieloStar. CieloStar will then send reimbursement checks for eligible expenses to participants on a regular basis or directly deposit them in your bank account. See pages [51 and 52](#) for more information.

CieloStar

Attn: Transportation Administration Dept.

730 2nd Avenue South, Suite 900

Minneapolis, MN 55402

Fax: (612) 335-9217 or (877) 491-6016

Q. I don't understand how I will save taxes on these expenses!

A. Here is an example. Please note that your savings may differ, based on the assumptions made in this example.

Parking Expenses: \$195	<u>Without</u>	<u>With</u>
Gross Income	\$1,000.00	\$1,000.00
Eligible Receipts	\$0.00	-\$195.00
Adjusted Gross	\$1,000.00	\$805.00
Assumed Tax Rate 30%	-\$300.00	-\$242.00
Net Income	\$700.00	\$563.00
Eligible Receipts	\$0.00	\$195.00
Adjusted Net	\$700.00	\$758.00

This is an example only. Your actual tax savings will depend on your own individual circumstances. Also, tax benefits are not guaranteed by the Employer.

2015 RUN-OUT SCHEDULE

Plan Year 1/1/2015 through 12/31/2015

Reimbursement Request Deadline
by Close of Business (4:30 PM CT)

TRANSPORTATION

FINAL →

01/30/2016

HEALTH AND DEPENDENT CARE FSA,
VEBA/HRA →

02/15/2016

All reimbursement requests for expenses for health care and dependent care (daycare), and VEBA/HRA accounts incurred through December 31, 2015 must be documented and received at CieloStar no later than February 15, 2016. Any funds remaining in your FSA account(s) after February 15 following the end of the plan year will be forfeited. When you pay a provider via U.S. mail or by phone using your debit card, the provider may not process the payment immediately. Consider this delay as your submission deadline of February 15, 2016 approaches.

Final Submission deadline for transportation accounts is January 30, 2016. Any funds remaining in your account after January 30 following the end of the plan year will roll over providing you have enrolled in the transportation plan for 2016.

You cannot use your debit card to pay for previous plan year expenses anytime during the new plan year. Reimbursement funds will be taken from your 2016 account. If you want to claim 2015 expenses but do not get the bill or EOB until 2016, you must submit a manual claim and documentation by February 15, 2016.

ADDITIONAL INFORMATION

CieloStar Reimbursement Procedures

A Benefits Debit Card can be swiped at point-of-sale or recorded on a bill similar to charging an expense to your credit card. Once issued, Benefits Cards are good for 3 years. If your card expires and you are currently enrolled, you will be issued a new card automatically. See [page 53](#) for details on this reimbursement process.

You can continue to file by claim form or submit on-line, if you prefer. To obtain a CieloStar claim form, go to the Knowledge Base on BenefitReady*. Health care expenses, dependent care, and transportation expenses will be reimbursed to you on a regular basis. *Complete online claims by logging into BenefitReady and linking to the WealthCare Admin system (see [page 56](#) for instructions).

Remember, expenses incurred during one plan year cannot be reimbursed with money contributed in a prior or subsequent plan year, nor can amounts deposited in one account be used to reimburse expenses from another account. In addition, reimbursements under a Flexible Spending Account are based on service provided not service paid, therefore simply providing proof of payment for services rendered or expected service does not meet the IRS reimbursement requirements.

To be reimbursed for eligible health care, dependent care, or transportation expenses, you must complete a reimbursement claim form, detailing your expenses and include itemized receipts documenting the expense. Acceptable documentation would include an itemized receipt, an insurance company explanation of benefits (EOB), or an itemized statement of services provided (not paid) from the provider. The following items must be present on your supporting documentation:

1. Description of Service
2. Date of Service Provided (not paid)
3. Providers Name (and Tax ID for Dependent Care)
4. Amount of Participant Responsibility

In the event that itemized documentation is not available you may ask your provider to complete and sign the appropriate box on the Reimbursement Claim Form. Please keep a copy of the reimbursement claim form and documentation for your files.

Completed reimbursement claim forms and supporting documentation can be submitted via fax or mailed to:

CieloStar
730 2nd Avenue South, Suite 900
Minneapolis, MN 55402
Fax: (877) 491-6016

If you need additional forms or have any questions, contact CieloStar at (877) 491-5979.

Reimbursement Duplication

Duplication of reimbursements, attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally will incur any penalties. The City of Saint Paul does not have the means to monitor your personal income tax and other financial affairs, and will not attempt to do so. You should maintain adequate records to support your claims in the event of an inquiry by the IRS, and keep copies of all documentation sent to CieloStar.

Direct Deposit

You can also sign up to have your reimbursements direct deposited into your checking or savings account. Go to the BenefitReady Knowledge Base to print a Direct Deposit Form.

Complete this form and fax or send to CieloStar at the address and/or fax number below. You would still file your claims by submitting claim on-line or sending in claim forms and documentation, but instead of CieloStar mailing your check, the funds would be transferred directly into your bank account on the distribution date. Please be aware that a pre-note is required, therefore your first reimbursement request might be mailed, and all subsequent reimbursements will be direct deposit.

Assistance Available

CieloStar's Customer Service Department is ready to help! Calls are answered every business day from 7:30 a.m. to 5:00 p.m. CT. Representatives can help you if you have specific questions about the health care account, dependent care account, and/or transportation account provisions. Their address and phone number is:

CieloStar

730 2nd Avenue South, Suite 900
Minneapolis MN 55402
Toll Free Fax: 877-491-6016
Phone: (877) 491-5979

BENEFITS DEBIT CARD

BENEFITS DEBIT CARD

One Card to Use for Flexible Spending and/or VEBA/HRA



Debit Card

The Benefits debit card can be used to pay for any reimbursable medical, daycare, VEBA/HRA, or parking expenses. It is as simple as swiping your card to pay for the expense at the point of service.

If you have a Benefits Card, that card is valid for three years. Check the “valid thru” date on your card. When you enroll in a FSA, the transportation account, and/or VEBA/HRA account for the first time, you will automatically receive a Debit Card in the mail. This card can be used to pay for covered expenses at time of service. No need to submit a claim form and wait to be reimbursed. You will need to save your receipts in case you are requested to submit substantiation for your charge.

A 55¢ monthly fee will be taken from your paycheck for the debit card throughout the plan year.

Spouses and qualified dependents can receive their own card at no additional charge. A form to request additional card(s) is available on the BenefitReady Knowledge Base.

You have total access to your account to review account balances and transaction history by clicking on the link to the WealthCare Admin (debit card website) in BenefitReady.

FSA Debit Card

Frequently Asked Questions

How does the CieloStar FSA Debit Card work?

Your card is loaded with the entire amount of your annual election so that you can begin using it on your eligibility date for health care expenses. It can also be used to pay for dependent care services, but only the current available balance amount can be spent (not pre-funded like health care).

How does the card know if my purchases are eligible expenses? What if I go to a discount store or supermarket to buy my prescriptions and get my eye exams?

Our system is set up to flag any transactions that don't correspond to your employer's health plan copays. Therefore, you may be asked to submit a receipt AFTER you've made the purchase so that we can substantiate your claim.

I've heard that over the counter medications aren't covered any more. Are there still some OTC items that can be purchased with my FSA Debit Card?

The majority of over the counter medications are no longer considered as eligible expenses under Flex Savings Plans without a prescription. The following is a sample list of products that remain FSA eligible: band aids, birth control, braces and supports, contact lens supplies and solutions, denture adhesives, diagnostic test monitors (pregnancy, ovulation), elastic bandages and wraps, first aid supplies, ostomy products (diabetic supplies), reading glasses, wheelchairs, walkers and canes. These products will automatically process through the system if the merchant is IAS compliant. If not, you will need to provide cash register receipts for these items.

What are IAS compliant merchants and why is this important?

IAS stands for Inventory Information Approval System. This system allows the debit card to review each item that is purchased from an IAS compliant merchant to see if it is eligible for reimbursement through your Flexible Spending Account. Many retail pharmacies such as Walgreens, CVS, Target, grocery stores and other large merchants have voluntarily complied with the IAS standard. To find out if your preferred merchant is IAS compliant, go to <http://www.sig-is.org> and click on Merchant List to review.

What if my doctor writes a prescription for an over the counter product that I use?

If your doctor writes a prescription for an over the counter product, you may send it to CieloStar with a completed claim form and a receipt. The prescription will be kept on file for one year. Any future claims that are submitted for the purchase of the product(s) will be approved if funds are available in your account. The prescription expires one year from the date it was written. At that time a new prescription will need to be submitted in order for reimbursement of that product to continue to be made.

Do I still need to save my receipts?

YES, PLEASE SAVE ALL OF YOUR RECEIPTS! You may need to send them to CieloStar for certain purchases. We'll let you know when we need them.

If I need to substantiate my purchases then what is the advantage of using the debit card?

IRS regulations require all expenses be properly documented to assure FSA eligibility. Doctor/hospital visits, dental charges and eyewear expenses that are outside the standard copays need to be documented with a receipt. The reason for this is that their charges are not submitted using UPC codes like pharmacies. We have no way of knowing the charge is for a no-show fee for a doctor's office, non-prescription designer sunglasses or teeth whitening products (ineligible services). The card allows you to purchase the goods and services and subsequently provide substantiation for the purchase, if necessary, to show that you are in compliance with IRS guidelines. The upside is that you don't have to pay for the service up front and wait to be reimbursed.

I received a receipt request from CieloStar. What do I need to provide?

You will want to provide a copy of the letter you received from CieloStar along with information indicating the date of service, nature of service received and amount insurance will be paying. Typically, this is an itemized receipt or Explanation of Benefits (EOB) from the insurance provider. This information can be faxed to 1-877-491-6016, scanned and emailed to flex@cielostar.com or mailed to CieloStar.

Do I need to activate the CieloStar FSA Debit Card when I receive it initially?

No activation is required; your elections will already be "loaded" on the card. The card may be used immediately to pay for eligible expenses.

What if I don't owe anything at point of sale (i.e. doctor's office) but get a bill later?

You can still use the card to pay the bill by writing your card number on the invoice and mailing it in, or by providing the card information over the phone.

Will the card work for my mail order pharmacy purchases?

Yes. In fact, using a mail order pharmacy is a great way to avoid receiving request letters.

What if I cannot find my Flex Debit Card or it was stolen?

If you are unable to locate your card, please contact CieloStar's Flex Department immediately at: 1-877-491-5979. CieloStar will deactivate your lost/stolen card and issue you a new card(s). Please note that it will take 7-10 days for your new card to arrive. Please be certain to provide an updated address if you have recently moved. At this time there is no cost for a replacement card.

What happens if my receipt shows I accidentally used the card for an ineligible expense?

Your FSA account can be used for eligible expenses ONLY. You are responsible for reimbursing your account if the card is used accidentally or intentionally for an ineligible expense. Your administrator will notify you if that should happen. Repayments must be settled by mailing a check payable to CieloStar for the entire amount of the ineligible expense.

What if I don't use all of my election by the end of the plan year?

For Health and Dependent Care Accounts you have until December 31 to incur expenses, and until February 15 to postmark reimbursement requests. **Any remaining funds after February 15 will be forfeited.** When you pay by mail or by phone using your debit card, the provider may not process the payment immediately. Plan for this delay as your submission deadline approaches. Please log on to www.wealthcareadmin.com often to check your balance so that you can monitor your account to make sure you spend your entire election amount.

Can I access my account online to check my balance and claims history?

Yes, log into csp.benefitready.com and click on the Benefits tab, then click on the FSA or HRA tab. Click on the link to the WealthCare Admin (debit card website). Follow the instructions to set up or view your account. You will be asked for an Employee ID, which is your social security number with no dashes. The Employer ID is OSOCSP. There are step by step instructions on Knowledge Base in BenefitReady if you need more help.



What does it mean when my Flex Debit Card is DECLINED at the merchant's location?

Various reasons can cause the card to be declined:

- ✓ you may be at an ineligible location;
- ✓ you may be asking for more money than what you have elected and/or contributed;
- ✓ the valid location you are visiting has been identified in our system as an invalid location;
- ✓ the card's magnetic strip has been compromised;
- ✓ the merchant's "credit swipe machine" may be malfunctioning; or
- ✓ you "swiped" the card and indicated "debit" rather than indicating "credit". (*Indicating debit" will cause an immediate rejection.*)

VEBA / HRA

VEBA/HRA

The City of Saint Paul has established a health reimbursement arrangement (HRA) that provides tax-free reimbursement of eligible health care expenses not paid by other insurance. Plan benefits are funded by the City using a Voluntary Employees' Beneficiary Association trust (VEBA). Unused funds in members' accounts are permitted to be carried over from year to year to build for future expenses.

VEBA contributions are based on your bargaining unit contract. Eligibility for City contributions into the VEBA is defined below:

Medical Plan	Coverage Level	City Contribution
Open Access with Deductible	Single	\$80.00 each month (\$960 for the year)
	Family	\$45.00 each month (\$540 for the year)

Eligible Expenses

This account can be used to pay for health care expenses incurred by yourself, your spouse and/or your eligible dependents after you enroll for medical coverage if:

- The expense would be deductible by you on your federal income tax return if you paid the expense directly, and
- The expense is not paid by any other health plan or from some other source.

Examples of eligible expenses are medical, prescription drug, dental, vision, and over-the-counter drugs, if accompanied by a physician's prescription. They include all eligible expenses allowed under [Medical FSA](#) (see [page 37](#)). In addition, an HRA allows COBRA premiums, Medicare premiums and long-term care premiums.

You can participate in both a medical flexible spending account (FSA) and a health reimbursement arrangement (HRA) in the same plan year. If you elect to participate in both, eligible expense reimbursements will always be paid from your FSA account first (because FSA is a use-it-or-lose-it plan) before they are paid from your VEBA/HRA account. Remember, unused VEBA/HRA funds automatically carry over from year to year. However, expenses do not carry over.

FILING Reimbursement claims

CieloStar is the claims administrator. You can submit claims by mail, fax, on-line, or by using your benefits debit card (see Debit Card section [on page 51](#)). Claim payments are processed regularly. If you submit via claim form, you may elect to receive your reimbursements by check or through direct deposit.

Claim forms are available to print from your www.BenefitReady.com account by clicking on Knowledge Base, Forms. The same claim form can be used for both medical FSA and HRA reimbursements.

You also have the option to submit claims [online](#). Save time and paper. See [page 35](#) for instructions.

You must submit any reimbursement requests for expenses incurred through your period of coverage for the prior year in order to be reimbursed from the prior year's contributions. When you pay a provider statement via U.S. mail or by phone using your debit card, the provider may not process the payment immediately. Consider this delay as your submission deadline on February 15, 2016 approaches. **Reimbursement requests for the VEBA/HRA must be received at CieloStar by February 15, 2016, 4:30 PM CT, for eligible expenses incurred during the 2015 plan year.**

Access to Claims and Balance Information

To access VEBA/HRA claims information and claims history, go to your account at csp.benefitready.com and click on FSA or HRA. This will bring you to a link to the WealthCare Admin (debit card) website. At this point you will need to enter a logon and password. To minimize confusion, you can use the same logon and password established for your BenefitReady account. You can then review your balances, claims history, report a lost or stolen debit card, or look up Frequently Asked Questions.

VEBA/HRA FAQs

How much and how often is my VEBA/HRA account funded?

The City of Saint Paul will fund \$80 each month for employees with single coverage and \$45 each month for those with family coverage.

Note: Employees enrolled in the Open Access with Deductible plan who complete all requirements for the Healthy Saint Paul program by the deadline will receive an additional incentive of \$75/month into his/her HRA/VEBA account. See pages 29-30 for details or visit www.healthy.stpaul.gov for more information.

How can I take money out of my VEBA/HRA account?

- 1) You can swipe your debit card at point-of-sale, or write the debit card account number on a bill similar to charging an expense to your credit card; or
- 2) You can complete a Claim Form and mail or fax it to CieloStar.* You will need to include proper substantiation of your expenses such as a detailed receipt or an Explanation of Benefits (EOB) from HealthPartners. *You can also submit online. See instructions on [page 35](#).

Can I participate in a flexible spending account also?

Yes. If you have both an FSA and HRA, the plan is designed to first deduct submitted expenses from your FSA. Once the FSA is exhausted, then your VEBA/HRA account is debited.

Is there any annual “use-it-or-lose-it” requirement?

No. Unlike Section 125 flexible spending accounts (FSAs), unused funds in your VEBA/HRA account are carried over from year to year.

What if my expense is more than the balance in my VEBA/HRA account?

You can submit the expense, but you will only be reimbursed up to the amount that is in your account at that time. The remainder of the expense will be carried forward until you have additional funds for reimbursement.

What expenses are eligible for reimbursement?

Eligible out-of-pocket expenses can include office visits, over-the-counter medications (if accompanied by a physician's prescription) and prescription drug co-payments; annual deductibles and many other medical, dental and vision costs not covered by your insurance plan(s). Tax-qualified long term care (subject to IRS limits), Medicare Part B, Medicare Part D, and Medicare supplement plan premiums are also eligible. Insurance premiums that are paid by an employer or that are deducted pre-tax through your or your spouse's Section 125 Cafeteria Plan are not eligible for reimbursement.

Whose expenses are eligible for reimbursement?

Qualified expenses incurred by you, your spouse, or any tax-qualified dependents are eligible for reimbursement. Tax-qualified dependents are defined in Internal Revenue Code Section 105(b) and described in IRS Publication 502.

Can any retiree medical premium be paid from my account?

Yes. The cost of any qualified medical insurance plan you elect to use during retirement can be paid or reimbursed from your account, including Medicare premiums.

What happens if I take a leave of absence, resign, or retire?

You may use your account until funds are exhausted.

What if I die before I use up my VEBA/HRA account?

If you are survived by a spouse or dependent children, they may submit requests for medical expenses reimbursements until your account is exhausted. If you have no surviving spouse or eligible dependent(s), the funds remaining in your account will revert back to the VEBA trust.

Who is responsible for managing the VEBA/HRA plan?

The VEBA is managed by a Labor Trust Committee as defined in the by-laws of the VEBA trust document. The Trustee is U.S. Bank. The HRA is governed by the City of Saint Paul and administered by CieloStar.

OPTIONAL INSURANCE

OPTIONAL INSURANCE

DENTAL INSURANCE

HealthPartners Dental Distinctions plan provides benefits for fillings, periodontics, endodontics, oral surgery, crowns, onlays, prosthetics and orthodontics.

Eligibility

The Dental Distinctions plan is available to employees who are eligible for insurance. However, you do not need to be enrolled in the health insurance plan to elect the optional dental coverage. Once you enroll, premiums will be deducted from your paycheck monthly, and you may not cancel coverage during the calendar year unless you experience a status change event, as defined on [page 40](#). If you choose to discontinue your coverage, you will have a 24-month waiting period.

PLEASE NOTE: If you are currently a member of the Dental Distinctions plan and don't cancel your optional dental plan during Open Enrollment, you will have elected, by default, to continue your participation in the Plan.

The 2016 premiums for dental insurance are unchanged from 2015.

<u>Monthly Cost:</u>	
Employee	\$21.53
Employee + 1	\$43.01
Family	\$78.22

Dental premiums will be deducted on a pre-tax basis, further reducing your cost.

Remember, you can save additional money by using a medical flexible spending account (FSA) to pay for expenses not covered by the dental plan.

Networks

The Dental Distinctions plan groups dentists and specialists into benefit levels based on cost and quality criteria. Choose a dentist or specialist from Benefit Level I to select the most appropriate care at the best cost. Or choose a dentist from Benefit Level II and pay a higher cost. The choice is yours. You never need a referral to see a specialist. Your Dental Distinctions plan network includes more than 2,400 providers across Minnesota, western Wisconsin, eastern North Dakota and South Dakota. You can also choose to see a provider who is not in the network and pay higher out-of-pocket costs.

Each family member may select a different clinic and benefit level and all members may change their selection at any time. There is no need to call to make a clinic change. With the optional dental plan, you can choose a different dental clinic than the one you chose under your medical plan for preventive services.

Plan Benefits

DENTAL SERVICES	BENEFIT LEVEL I PROVIDERS	BENEFIT LEVEL II PROVIDERS	ANY LICENSED DENTIST
Annual Maximum (eligible benefit per person per year)	\$1,250	\$750	\$500
Combined across tiers			
Preventive/Diagnostic Care	100%	100%	100%
Sealants	100%	100%	100%
Annual Deductible (does not apply to preventive care)	\$25 per person \$75 per family	\$50 per person \$150 per family	\$50 per person \$150 per family
Basic I Services			
❖ Amalgam Fillings	100%	80%	80%
❖ Posterior Composites	80%	50%	50%
❖ Non-Surgical Periodontics	60%	50%	50%
❖ Endodontics (Root canal therapy)	60%	50%	50%
Basic II Services			
❖ Surgical periodontics	60%	50%	50%
❖ Complex Oral Surgery	60%	50%	50%
❖ Crowns, onlays	50%	50%	No Coverage
Prosthetics			
❖ Bridges, dentures & partial dentures	50%	50%	No Coverage
❖ Dental Implants	50%	50%	No Coverage
Orthodontics (no deductible)			
❖ For dependents to age 19	50%	50%	
❖ Lifetime maximum	\$750	\$500	No Coverage
❖ Does not apply to annual maximum (separate benefit)			

HealthPartners Orthodontic Discount

With the average orthodontic bill approaching \$6,000, our 15 percent discount provides you with a significant savings opportunity. Here's how it works:

- ◆ This discount is available to HealthPartners dental members of all ages whether or not you have orthodontic coverage!
- ◆ You will receive a 15 percent discount on all care.
- ◆ Members will receive discounted services at any of the 19 Orthodontic Care Specialists, Ltd. metro locations, HealthPartners dental clinics and at WOW Orthodontics locations.
- ◆ Simply present your HealthPartners dental ID card at your first visit to obtain your discount.

To learn more, check out our website at healthpartners.com or visit orthodonticcarespecialists.com or wowortho.com for location details.

Enrollment

To enroll in the HealthPartners Dental Distinctions plan, go online to BenefitReady and elect employee, employee +1 or family coverage.

Identification Cards/Plan Information

If you are enrolling in HealthPartners Dental Distinctions plan for the first time, you will receive an identification (ID) card for each covered family member along with a Group Membership Contract and Member Handbook. Continuing members will receive a Group Membership Contract and Appendix. You will receive these materials by January 1, 2016.

Provider Information and Directories

You can obtain Dental Network information by calling HealthPartners Member Services at 952-883-5000 or 800-883-2177, as well as at the HealthPartners website. Find a provider by clicking on “Find a doctor, dentist or specialist,” then “Group Dental Networks.” Select “HealthPartners Dental Distinctions” in the dental plans section.

Additional Dental Plan Benefits

Diabetes and Maternity Care

More and more research points to a connection between good oral and overall health, especially for those who are diabetic or pregnant. That’s why HealthPartners now offers enhanced coverage above and beyond standard plan benefits, such as additional exams, cleanings and other necessary periodontal services, to pregnant and diabetic members with periodontal (gum) disease.

Little Partners Dental – Kids 12 and Under are Free

A lifetime of good oral health starts when you’re young. HealthPartners covers all services included in your dental plan that are performed by network providers for all enrolled children 12 and under at 100 percent, with no deductibles or coinsurances.

Dental Implants

In some instances dental implants are the best option. In addition to HealthPartners current coverage of prosthetics for implants, HealthPartners is expanding the benefit to include the surgical portion of the treatment, too.

Frequently asked questions

Q. Do I have to be enrolled in the health insurance plan to opt for the voluntary dental plan?

A. No, you do not need to be enrolled in the health insurance plan; you only need to meet the eligibility requirements listed on [page 61](#).

Q. Is preventive dental still covered under my health insurance plan?

A. Yes. However, the two cleanings under each plan will be coordinated. You will not be eligible for four cleanings and exams per year, and preventive charges do not apply toward your dental annual maximum.

Q. Does my dental clinic need to be the same for my health insurance plan as for my optional dental plan?

A. No, you may choose a different dental clinic under each plan.

Q. Is there an out-of-network option?

A. Yes.

Q. Is the annual maximum per family or per member?

A. Each family member has an annual maximum benefit of \$1,250 or \$500, depending upon Benefit Level 1, Benefit Level 2 or any licensed dentist.

Q. Are all charges, including preventive and diagnostic, applied toward the annual maximum?

A. Yes. Any benefits HealthPartners pays for your dental care and treatment will be applied toward your annual maximum benefit. Note: if you carry HealthPartners health insurance, your preventive/diagnostic charges will be covered under that plan, leaving your annual maximum intact for regular and special restorative care.

Q. Is dental insurance subject to enrollment each year?

A. Yes. You can choose to enroll or cancel participation for the following year during Open Enrollment. However, enrollees who cancel must wait 24 months before re-enrolling.

Q. Does HealthPartners cover “Work in Progress”?

A. There are certain circumstances where HealthPartners would not cover work in progress. For example:

Crowns: If a tooth has been prepared and impressions have been taken before the member was covered under a HealthPartners dental contract, the crown will not be covered.

Root Canal Treatment: If root canal treatment was initiated (pulp chamber has been opened) before the member was covered under a HealthPartners dental contract, the root canal is not covered.

Prosthetics: Treatment including fixed and removable prosthetics, which began or were ordered before a member was covered under a HealthPartners dental contract, is not covered. In the case of dentures, ordered means that impressions have been taken from which the denture will be prepared. In the case of fixed prosthetics (bridgework), the teeth that serve as abutments or support have been prepared and impressions have been taken.

Orthodontics: Members whose orthodontic treatment is in progress (bands are still in place) should have their treating dentist submit a claim form with the following information: total treatment cost, total length of treatment, down payment and payments made by previous carrier.

LIFE INSURANCE

Employer Group Life Insurance

Term life insurance and accidental death or dismemberment insurance is provided by the City of Saint Paul for most of its employees. All employees of the City of Saint Paul who have met the eligibility requirements for the City-sponsored health insurance plan are eligible for employer group life insurance. Your **BenefitReady** Account indicates your amount of coverage as specified in your collective bargaining unit agreement or City Council Resolution.

Optional Life Insurance

The City's optional term life insurance program has been designed exclusively for City of Saint Paul employees. By updating your life insurance, you can make sure your loved ones would be financially secure if you were to die. Your **BenefitReady** Account indicates the current amount of life insurance coverage you chose for yourself, your spouse, or your dependents, in addition to the employer-paid insurance.

The following information is intended as a general guide to the term life insurance plan. Full details of the insurance program are provided in the Certificate of Insurance available on the City website. You can contact Employee Benefits at (651) 266-8892 more information.

Insurance Coverage Available

You can apply for up to \$300,000 of additional life insurance in units of \$5,000. Your plan covers death from any cause (excludes suicide for two years) after you enroll in the plan.

New employees who enroll in this plan within 31 days of date of hire may elect an insurance amount up to the guarantee issue amount of two times their annual earnings (rounded to the nearest \$5,000), not to exceed the amount shown below per their age at employment.

New Employees

Age at Employment	Guaranteed Issue Amounts
Under 35	\$100,000
35-39	\$ 50,000
40-44	\$ 35,000
45-59	\$ 25,000
60 and over	\$ 0

After this initial enrollment period, you will have to provide evidence of insurability and complete a health questionnaire. Coverage will take effect following approval of the application by the insurance company. To apply for increased coverage during the annual enrollment, make the election in your **BenefitReady** Account and print out and complete the health questionnaire available in your **BenefitReady** Account.

Insurance for Spouse

This plan offers the opportunity to insure your spouse in the same amounts and increments which are available to employees. It is not necessary to purchase employee life to be eligible for additional spouse life coverage. If you are applying for coverage as both an employee and a spouse, the total amount of coverage on such individual cannot exceed \$300,000. With insurance covering both heads of your household, you can be more certain of a secure future for your family. New employees are eligible for \$10,000 of spouse coverage on a guaranteed approval basis. Existing employees can make the election during annual enrollment in your BenefitReady Account and then print out and complete the health questionnaire available in your BenefitReady Account to increase coverage.

Insurance for Children

This plan also allows you to obtain life insurance coverage for your children. For only 70¢ a month, all of your eligible children can be insured from live birth to 26 years of age. The amount of insurance on the life of each insured child shall be \$10,000 except that the amount on an insured child age live birth to six months shall be limited to \$1,000. In addition, if an insured employee's first eligible child dies within 31 days of birth, but prior to the employee enrolling for child life coverage, the insurance amount payable will be \$1,000. New employees may choose this coverage on a guaranteed approval basis. Existing employees can make the election during annual enrollment in your BenefitReady Account and then print out and complete the health questionnaire available in your BenefitReady Account for each child to increase coverage.

Accidental Death Benefits

Employees and spouses who enroll in the optional life insurance plan are both eligible for double benefits if either dies as a result of an accident. For example, if you had \$50,000 of life insurance and then died due to an accident, \$100,000 would be paid to the person you selected as your beneficiary. The monthly cost in the table below includes this benefit.

Dismemberment Benefits

This insurance plan also pays benefits if you or your insured spouse should suffer loss of limb or eyesight. The plan exclusions existing for both dismemberment and accidental death are fully detailed in the plan certificate.

Monthly Benefit and Cost

The employee and spouse's life and AD&D insurance premium is based on age. (See table below for Optional Life and AD&D Insurance Premiums). Rates are determined by your attained age each January 1.

Employee or Spouse Age	Monthly Cost per \$1,000
Under 30	\$0.05
30-34	\$0.05
35-39	\$0.05
40-44	\$0.07
45-49	\$0.09
50-54	\$0.14
55-59	\$0.23
60-64	\$0.36
65-69	\$0.66
70+	\$1.07

Beneficiary

If you do not name a beneficiary, or if there is no named beneficiary surviving at the time of your death, the amount of your insurance will be paid according to the following order of priority: 1) Your surviving lawful wife or husband; 2) Your surviving children in equal shares; 3) Your surviving parents in equal shares; 4) The duly appointed legal representative of your estate. "Children" means only first generation lawful bodily issue and legally adopted persons. Beneficiary designation is completed online in your BenefitReady Account.

Continuation, Conversion and Portability**Continuation:**

If you leave City employment or retire, you can continue to purchase term insurance for 18 months through the City's plan. This allows you to continue life insurance coverage at the same group rates you were paying as an active employee.

Portability:

After 18 months of continuation, you can choose to port your coverage. Portability allows employees who are no longer eligible under the group policy to continue basic and optional term life coverage under the group plan. Portability is not allowed if you are not actively at work due to sickness or injury. Spouse and dependent coverage may also be ported if the employee continues his or her own coverage. No health questions will be asked when you port your insurance, as long as you contact Employee Benefits at (651) 266-8892 to apply within 31 days from the last day of coverage. Portability does include a maximum amount for spouse life, up to the previous amount (not to exceed \$150,000) and benefit reductions for both employee and spouse at age 65. All coverage terminates at the employees age of 70. Conversion is available at any time after porting your coverage.

Conversion:

After 18 months of continuation, you can continue to purchase additional insurance by changing to an individual policy provided by the insurance underwriters. No health questions will be asked when you convert your insurance, as long as you contact Employee Benefits at (651) 266-8892 to apply within 31 days from the day the 18 month continuation period ends. Individual policy premiums will be based on you and/or your spouse's age at application. You can convert the same amount of insurance or less, but not more than what you currently are enrolled in.

Certificate of Insurance

Your Certificate of Insurance which provides in detail the provisions of the City's life insurance program is available on the Saint Paul web site at:

<http://www.stpaul.gov/benefits>

LIFESUITE

Your employer group life insurance plan also includes LifeSuite which provides support and resources for life's every day and extraordinary needs. LifeSuite includes the following services at no cost to you:

Legacy Planning Resources – From Securian

The Legacy Planning Resources are available to active and retired employees and your families to deal with the loss of a loved one or plan for your own passing. Topics covered include asset distribution, last wishes, estate plans, last will and testament, power of attorney, health care directives, beneficiary designations and document locator.

Legacy Planning Resources also offers information for planning or pre-planning a funeral or memorial service. Topics covered include:

- Planning considerations, such as locating documents, choosing burial or cremation, and notifying family members
- Paying for a funeral or memorial service
- Filing an insurance claim
- Survivor resources, including a survivor checklist
- Express Assignment funeral home assignment service –benefits can be assigned directly to the funeral home to cover expenses

Legal, Financial and Grief Counseling – From Ceridian HCM, Inc.

Legal, Financial and Grief Services offer the ability to draft a simple will or other legal documents, a free 30-minute consultation with an attorney for each unique legal issue and guidance from accredited financial consultants regarding credit management, budgeting, mortgage/refinancing, retirement/401K and basic estate planning. This service also provides caring, confidential support with grief, anger or anxiety and access to community resources.

Visit the website at www.lifeworks.com (Username: lfg; Password: resources) or call 1-877-849-6034.

Travel Assistance Services – From RedpointWTP LLC

Travel Assistance provides all active U.S. employees covered under the group life insurance program, and their spouses and dependents, with 24/7/365 access to emergency assistance, medical professional locator services, and transport services when traveling 100 or more miles away from home. Online pre-trip resources and assistance replacing lost or stolen luggage, medication or other critical items is also available. In addition, medically necessary repatriation and repatriation of mortal remains is provided.

You do not need to enroll. Just become familiar with the services and use them if and when you need travel assistance. Visit the website at www.lifebenefits.com/travel or call 1-(855)-516-5433 in the U.S. and Canada. Call collect, +1-(617)-426-6603 from other locations.

SHORT TERM DISABILITY INSURANCE

Short term disability insurance is available to eligible City of Saint Paul employees through Standard Insurance Company. Short term disability is just what its name implies; an insurance program that pays you a monthly income while you recover from a short term (less than six months) injury or illness. The short term disability insurance program allows you to receive your monthly short term disability benefit plus any sick leave or compensated leave you choose to take, as long as you don't receive more than 100% of your normal salary (the minimum benefit you will receive from short term disability is \$25 per week, even if it exceeds the 100% of weekly pay).

The following information is intended as a general guide to the short term disability program. Full details are provided in the Certificate of Insurance. You can contact Employee Benefits at (651) 266-8890 for more information.

Insurance Coverage Available

Under the City of Saint Paul's plan, you can apply for a monthly benefit of up to \$2,000, provided it doesn't exceed 66-2/3% of your gross monthly salary. You could be paid up to a maximum of 26 weeks for short term disability, depending on your physician's verification of disability. These are cash payments made to you to help compensate for the loss of wages following your injury or illness. This is insurance coverage for an injury or illness you may sustain while not on the job. No benefits are paid if you are eligible for workers compensation. You begin to receive the benefits on the first day of an accident, or on the eighth calendar day of an illness which prevents you from working. The claim determination is made within 5 business days from when all the required claim documentation is received. Your first check will arrive within 60 days after you satisfy Proof of Loss.

During open enrollment (October 5 to October 16, 2015), you can make any changes by making a new election in your BenefitReady Account. Employees currently enrolled in short term disability insurance may increase by \$100 in monthly benefits. Employees can also increase to a higher monthly maximum or enroll for the first time if you are not currently a participant. Employees increasing by more than \$100, or enrolling for the first time, will be subject to a late enrollment provision. If subject to this provision, you will have a 60 day benefit waiting period for all non-accident related claims that are filed within the first 12 months of coverage for amounts over the \$100 increase or for the full amount of coverage if electing during open enrollment. Benefits due to an accident will still begin on the first day. You can contact Employee Benefits at (651) 266-8890 for more information.

New employees who enroll in this plan within 45 days of their date of hire may elect up to their maximum benefit.

Monthly Benefit and Cost

Premium payments for short term disability insurance are automatically deducted from your paycheck. As shown in the table, the cost of short term disability insurance is \$1.17 per month per \$100 monthly benefit.

The cost of your short term disability coverage depends on the monthly benefit amount you select. You may choose any benefit amount shown in the chart below up to the maximum monthly benefit amount that corresponds with your monthly salary.

Employee's Monthly Salary	Maximum Monthly Benefit	Monthly Premium
\$ 300	\$ 200	\$ 2.34
\$ 450	\$ 300	\$ 3.51
\$ 600	\$ 400	\$ 4.68
\$ 750	\$ 500	\$ 5.85
\$ 900	\$ 600	\$ 7.02
\$1,050	\$ 700	\$ 8.19
\$1,200	\$ 800	\$9.36
\$1,350	\$ 900	\$10.53
\$1,500	\$1,000	\$11.70
\$1,650	\$1,100	\$12.87
\$1,800	\$1,200	\$14.04
\$1,950	\$1,300	\$15.21
\$2,100	\$1,400	\$16.38
\$2,250	\$1,500	\$17.55
\$2,400	\$1,600	\$18.72
\$2,550	\$1,700	\$19.89
\$2,700	\$1,800	\$21.06
\$2,850	\$1,900	\$22.23
\$3,000+	\$2,000	\$23.40

Definition of Disability

- ◆ **Occupation Test:** You are considered disabled if due to an injury, sickness, or pregnancy, you are unable to perform one of the material duties of your regular occupation.
- ◆ **Earnings Test:** If you are working and are not disabled by the occupation test, you will still be considered disabled if an injury, sickness, or pregnancy prevents you from earning more than 80% of pre-disability pay.

Determination of disability is made by the insurance company.
The information above is just a general definition.

Minimum/Maximum Benefit

When combined with your short term disability benefit, you may also receive sick pay or partial disability earnings provided you don't exceed 100% of your regular weekly pay (please note the minimum benefit you will receive from short term disability is \$25 per week, even if it exceeds the 100% of weekly pay). The excess, if any, will be subtracted directly from your short term disability benefit.

Restrictions

The plan doesn't cover injury or sickness resulting from commission of a felony or if benefits are payable under any workers' compensation, employers liability occupational disease law, or similar law or act.

Continuation and Conversion

If you leave employment or retire, you cannot continue to purchase this coverage or continue to participate in the City's short term disability program.

Certificate of Insurance

Your Certificate of Insurance which provides in detail the provisions of the City's short term disability insurance program is available on the Saint Paul web site at:

<http://www.stpaul.gov/benefits>

See the Enrollment and Claim procedure section about filing a short term disability claims.

LONG TERM DISABILITY INSURANCE

The long term disability insurance program is offered to eligible City employees through Standard Insurance Company. Long term disability means you can receive a monthly income while recovering from a long term (over six months) illness or injury that prevents you from working. Long term disability insurance is a practical and cost-effective way to assure that you have continued income if you become disabled and can no longer work. The following is intended as a general guide to the long term disability program. Full details of the insurance program are provided in the Certificate of Insurance. You can contact Employee Benefits at (651) 266-8890 for more information, and representatives will be available to assist you during open enrollment information sessions.

Insurance Coverage Available

You can receive a monthly benefit check based on your annual salary. You can receive as little as \$500 a month to as much as \$5,000 a month from the long term disability benefits provided you do not exceed 60 % of your salary. Payment of benefits starts on the latter of six months of continuous disability, the end of short term disability benefits, or the end of all sick leaves, donated sick leave, vacation pay, or other salary continuance. Remember that short term disability benefits can cover you up to 26 weeks. The length of the benefit payment is shown below:

Age at Disability	Length of Payment
Prior to age 62	To the day before retirement age*
At age 62	The longer of 42 months or the day before retirement age
At age 63	The longer of 36 months or the day before retirement age
At age 64	The longer of 30 months or the day before retirement age
At age 65	24 months
At age 66	One year, 9 months
At age 67	One year, 6 month
At age 68	One year, 3 months
Age 69 or more	12 months

* Retirement Age means the Social Security Normal Retirement Age

New employees who enroll in this plan within 45 days of their date of hire may elect up to their maximum benefit on an automatic approval basis. Coverage is subject to the pre-existing condition restriction. Evidence of Insurability is required if you apply more than 31 days after you become eligible.

During open enrollment (October 5 to October 16, 2015), employees who currently participate in the plan can increase their monthly benefit up to the maximum for their salary by making a new election in your BenefitReady Account. Employees who do not currently participate and wish to enroll during the annual enrollment will make the election in your BenefitReady Account and print out and complete the health questionnaire available in your BenefitReady Account. Coverage will take effect following approval of the application by the insurance company. New amounts are subject to the pre-existing condition restriction.

Monthly Benefit

The cost of your LTD protection is determined by the amount of coverage you choose. To determine the maximum amount for which you are eligible, locate your monthly salary in the first column, and cross over to the next column, Maximum Monthly Benefit Amount. You may enroll for any amount of coverage as shown up to that maximum amount. Before you enroll, make sure you understand how benefits are calculated.

Your Gross Monthly Salary	Maximum Monthly Benefit Amount	Your Gross Monthly Salary	Maximum Monthly Benefit Amount
Minimum \$1,000	\$ 500	\$ 4,667	\$ 2,800
\$ 1,000	\$ 600	\$ 4,834	\$ 2,900
\$ 1,167	\$ 700	\$ 5,000	\$ 3,000
\$ 1,334	\$ 800	\$ 5,167	\$ 3,100
\$ 1,500	\$ 900	\$ 5,333	\$ 3,200
\$ 1,667	\$ 1,000	\$ 5,500	\$ 3,300
\$ 1,834	\$ 1,100	\$ 5,667	\$ 3,400
\$ 2,000	\$ 1,200	\$ 5,834	\$ 3,500
\$ 2,167	\$ 1,300	\$ 6,000	\$ 3,600
\$ 2,334	\$ 1,400	\$ 6,167	\$ 3,700
\$ 2,500	\$ 1,500	\$ 6,334	\$ 3,800
\$ 2,667	\$ 1,600	\$ 6,500	\$ 3,900
\$ 2,834	\$ 1,700	\$ 6,667	\$ 4,000
\$ 3,000	\$ 1,800	\$ 6,834	\$ 4,100
\$ 3,167	\$ 1,900	\$ 7,000	\$ 4,200
\$ 3,334	\$ 2,000	\$ 7,167	\$ 4,300
\$ 3,500	\$ 2,100	\$ 7,334	\$ 4,400
\$ 3,667	\$ 2,200	\$ 7,500	\$ 4,500
\$ 3,834	\$ 2,300	\$ 7,667	\$ 4,600
\$ 4,000	\$ 2,400	\$ 7,834	\$ 4,700
\$ 4,167	\$ 2,500	\$ 8,000	\$ 4,800
\$ 4,334	\$ 2,600	\$ 8,167	\$ 4,900
\$ 4,500	\$ 2,700	\$ 8,334 up	\$ 5,000

Monthly Cost

Premium payments are automatically deducted from your paychecks. The following table shows what the monthly cost would be per \$100 monthly benefit (\$500 minimum required):

Age	Cost per Month per \$100	Cost per Month per \$500
00-24	\$.11	\$.55
25-29	\$.16	\$.80
30-34	\$.22	\$ 1.11
35-39	\$.34	\$ 1.70
40-44	\$.51	\$ 2.55
45-49	\$.79	\$ 3.95
50-54	\$ 1.17	\$ 5.85
55+	\$ 1.27	\$ 6.35

Use the following format to calculate your cost:

Example: Age 38 electing a \$1,500 monthly benefit

$$\begin{array}{rcl} \$1,500 & & \\ \times \text{ (Monthly benefit)} & & \\ \hline & .34/\$100 & = \\ & \text{(Cost for age bracket)} & \\ \hline & & \$5.10 \text{ per month} \\ & & \text{(Cost per month)} \end{array}$$

Integrated Benefits

You can receive long term disability benefits in **addition** to income received from other sources. The maximum benefit payable from **all** sources is 70% of salary. The payable benefit is coordinated with other disability income. If the sum of benefits received from other sources plus the long term disability monthly benefit exceeds 70% of the disabled person's monthly earnings, the long term disability benefit will be reduced by the excess. Other sources of income could include retirement or disability benefits from a retirement plan, workers compensation, social security, etc. Please note that the minimum benefit you will receive from long term disability insurance is \$100 per month, even if you are receiving in excess of 70% of salary from other sources.

Definition of Disability

- ◆ **Occupation Test:** You are considered disabled if, during the first 36 months of a period of disability, you are under the regular care of a licensed physician other than yourself and are unable to perform the material duties of your regular occupation or employment. After the first 36 months of a period of disability, you will continue to be considered disabled if you are unable to perform the material duties of any and every gainful occupation or employment for which you are, or become, reasonably fitted by education, training, or experience.
- ◆ **Earnings Test:** If you are working and are not disabled by the occupation test, you will still be considered disabled during any month you are not able, because of injury, sickness, or pregnancy, to earn more than 80% of your pre- disability monthly earnings.

Determination of disability is made by the insurance company.
The information above is just a general definition.

Restrictions

Coverage for pre-existing conditions will begin 12 months following the effective date of coverage provided that you are actively at work at that time and have been insured under the plan for a full year without interruption. Pre-existing conditions are those for which you sought treatment, or taken medication, during the three months prior to the effective date of coverage. In addition, you are not covered if the injury or illness resulted from war or any act of war, whether declared or not; intentionally self-inflicted injury, while sane or insane; or taking part in committing an assault or felony.

Return To Work Services

While Standard's disability plans provide financial support during a period of disability, resources are also devoted through their **Return to Work programs and Reasonable Accommodation Expense benefits**. The goal is to help employees get back to work and regain a healthier, more productive lifestyle. These services assist or incent employees to return work, if the disability allows.

Continuation and Conversion

If you leave employment, you can convert to your own long term disability plan. The benefits of the conversion policy will be those offered by the insurance company for conversion at the time you apply. To be eligible for conversion, you must have been insured under the long term disability plan for at least 24 months, apply within 31 days of termination, and pay the required premium. The availability of the conversion is dependent upon the reason for termination of coverage. Conversion plan provisions and costs may differ from the in-force policy. To apply for conversion, you can call employee Benefits at (651) 266-8890.

Survivor Benefit

If a disabled insured dies while receiving benefits, the disability benefit will continue to be paid for three months to the person's spouse. If the insured has no spouse, the benefit will be paid to children under age 25 and unmarried on the day the disabled insured dies. If there are no survivors, no benefit will be paid.

Certificate of Insurance

Your Certificate of Insurance which provides in detail the provisions of the City's long term disability insurance program is available on the Saint Paul web site at:

<http://www.stpaul.gov/benefits>

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental death and dismemberment insurance is available to City of Saint Paul employees through Standard Insurance Company. Eligible employees are entitled to purchase this insurance to provide added benefits in the event of loss of life or limb. The accidental death and dismemberment policy provides for a lump sum payment in the event of the accidental loss of life, dismemberment, or loss of sight. In the event of an accidental death, your beneficiary will receive accidental death and dismemberment benefits in addition to any other life insurance benefits for which you qualify.

The following information is intended as a general guide to the accidental death and dismemberment insurance policy. Full details of the insurance program are provided in the Certificate of Insurance. You can contact Employee Benefits at (651) 266-8892 for more information.

Insurance Coverage Available

Employees can purchase from \$5,000 to \$100,000 in accidental death and dismemberment benefits (in \$5,000 increments). All employees may apply for a maximum of \$100,000, no health questions are asked. Spouse coverage is also available in \$5,000 increments and is limited to 100% of the coverage selected by the employee, to a plan maximum of \$100,000. Employees must enroll in the plan in order to elect spouse coverage. You can enroll for coverage in your **BenefitReady Account**.

Monthly Benefit and Cost

This insurance provides up to \$100,000 coverage at very little cost. The cost per \$1,000 of coverage is \$.02 per month. Coverage is available in \$5,000 units. Monthly premium payments are automatically deducted from your paychecks.

Beneficiary

If you do not name a beneficiary, or if there is no named beneficiary surviving at the time of your death, the amount of your insurance will be paid according to the following order of priority: 1) Your surviving lawful wife or husband; 2) Your surviving children in equal shares; 3) Your surviving parents in equal shares; 4) Your brothers and sisters; 5) Your estate. "Children" means only first generation lawful bodily issue and legally adopted persons. Beneficiary designation is completed online in your **BenefitReady Account**.

Continuation and Conversion

If you leave employment or retire, you cannot continue to purchase this coverage or continue to participate in the accidental death and dismemberment program.

Certificate of Insurance

Your Certificate of Insurance which provides in detail the provisions of the City's accidental death and dismemberment insurance program is available on the Saint Paul website at:

<http://www.stpaul.gov/benefits>

City of Saint Paul

LONG-TERM CARE INSURANCE

All participants have the flexibility to choose from several plan options based on their level of risk tolerance, costs in their local area, or income level.

Benefit Exhibit for Group Long-Term Care Insurance

FEATURES AND BENEFITS	OPTION 1	OPTION 2	OPTION 3
Maximum daily benefit for nursing home care. The eligible expense per day of nursing home care, up to the maximum nursing home care benefit chosen by you.	\$80	\$120	\$150
Maximum daily benefit for assisted living facilities. 100% of the eligible expense per day to the amount shown at right.	\$64	\$96	\$120
Maximum monthly benefit for community based care. The eligible expenses per month for community based care. This is a flat monthly amount, not administered as a daily amount.	\$1,800	\$2,700	\$3,375
Lifetime maximum benefit – The lifetime maximum benefit is a “total pool of money” the insured can use for all eligible long term care expenses. The lifetime maximum benefit will automatically increase when your daily benefit for nursing home increases. Choice of a 3.4 Year or 5 Year Lifetime Maximum.	3.4 YEAR LIFETIME MAXIMUM BENEFIT \$100,000 \$150,000 \$187,500 5 YEAR LIFETIME MAXIMUM BENEFIT \$146,000 \$219,000 \$273,750		
Waiting period. A licensed healthcare practitioner must certify you as chronically ill. 60 service days for Nursing Home Care. 15 service days for Community Based Care.	✓	✓	✓
Temporary bed holding benefit – Your plan will pay the eligible expense not to exceed the maximum daily benefit for nursing home care, up to 21 calendar days per year, to hold your bed in the nursing home during your absence.	\$1,680	\$2,520	\$3,150
Emergency alert - Independent living at home may require the ability to summon help quickly with an emergency alert system. Monthly rental or lease fees for such equipment are covered up to or equal to the daily community based care benefit.	\$60	\$90	\$112.50
Caregiver training benefit – Your plan will pay the eligible expense incurred for caregiver training up to the caregiver benefit stated at to the right. Caregiver training of this type is covered up to a total of three times the community based care benefit.	\$180	\$270	\$337.50
Care assist benefit – Designed to temporarily relieve an informal caregiver of the duties for caring for the insured. Your plan will pay the eligible expense incurred up to the daily nursing home care benefit with a maximum benefit of 14 calendar days per year.	\$1,120	\$1,680	\$2,100

ADDITIONAL FEATURES

Hospice Care. Terminally ill individuals can receive hospice care to alleviate pain and make them as comfortable as possible during the final stages of illness. In order to receive hospice care benefits, a physician must certify that you have less than six months to live.

Refund of Premium at Death. If the insured dies prior to age 65, this benefit will be returned to the beneficiary in the form of all premiums paid less any benefits paid while on claim. The amount of refund is 100%, if death occurs prior to age 65. The amount decreases by 10% each year until age 75. After attainment of age 75, there is no refund of premium.

Benefit Account (OPTIONAL). This benefit provides for a reduced lifetime maximum benefit, if coverage is lapsed after being insured for at least three continuous years.

Inflation Protection Options. Guaranteed Benefit Increase Offering (Standard): You will periodically be given opportunities to increase your benefit amount and lifetime maximum on a guarantee issue basis. The amount of the daily benefit increase will not be less than a compounded annual 5% rate compounded annually.

Inflation Protection Options - Automatic Benefit Increase (OPTIONAL - Available only on the \$80 and \$120 Daily Benefit Options). This feature will automatically increase the amount of your daily nursing home and lifetime maximum benefits each year by 5% of the prior year's amount for life, without ever increasing your premiums.

ADDITIONAL

Eligibility	All persons eligible for other employee benefits hired before February 1, 2015 may enroll, as well as their spouses, retirees and their spouses, parents, parents-in-law, grandparents and grandparents-in-law. Spouses of employees, retirees and their spouses, parents, parents-in-law, grandparents and grandparents-in-law may enroll regardless of whether the employee enrolls and premiums are based on their own age, not the employee's.
Underwriting	At the time of hire, employees need only be actively at work and work at least 20 or more hours per week on the effective date of coverage to qualify. No other questions will be asked. After the initial enrollment, employees must complete a short application form application. At all times, spouses must complete a short application form and parents, parents-in-law, grandparents, and grandparents-in-law must complete a long form application.
Cost	Premiums are based on a person's age at the time the policy becomes effective. Premium quotes are available up to age 90 upon request. Enrollees can apply for a state tax credit of up to \$100 per policy per year.
Payment	employees and spouses will pay their premiums through payroll deduction. Retirees and their spouses, parents, parents-in-law, grandparents, and grandparents-in-law may pay their premiums through direct billing or automatic bank draft.
Portability	An employee may continue coverage if he/she retires or otherwise leaves employment. The coverage and rates remain the same.

To request an enrollment kit or if you have any questions, please employee Benefits at (651) 266-6500 for more information.



Please note: CNA will no longer be accepting new applications as of 1/31/2016.

The City of Saint Paul is in the process of evaluating alternative options that would allow them to continue to offer a Long Term Care benefit option.

ENROLLMENT AND CLAIM PROCEDURES

The City of Saint Paul's optional life insurance program is underwritten by the Minnesota Life Insurance Company. The short term disability insurance, long term disability insurance and accidental death and dismemberment insurance policies are offered through Standard Insurance Company. CNA is the insurance carrier for Long Term Care Insurance. Disability coverage is subject to enrollment and cancellation as a new employee and at open enrollment only. Mid- year changes are not allowed. Please consider your options carefully.

Enrollment

Enrollment is easy.

- If you are changing current optional coverage amounts, you need to show that change in your **BenefitReady** Account. You can print the health questionnaire, if required, directly from your **BenefitReady** Account.
- Remember that all optional life insurance increases require the health questionnaire.
- A health questionnaire for long term disability will not be required if you are a new hire. If you are currently enrolled in the long term disability plan, you can increase your monthly benefit directly in your **BenefitReady** Account. If you are not currently enrolled in the long term disability plan, a health questionnaire will be required.
- If you are not currently enrolled in the short term disability plan, you may elect your monthly benefit directly in your **BenefitReady** Account. However, if you are not a new hire, you will be subject to a 60 day benefit waiting period for all non-accident related claims that are filed within the first 12 months of coverage. Benefits due to an accident will still begin on the first day.
- If you are currently enrolled in short term disability, you can increase your monthly benefit by \$100 directly in your **BenefitReady** Account. Higher amounts will be subject to a 60 day benefit waiting period for all non-accident related claims that are filed within the first 12 months of coverage. Benefits due to an accident will still begin on the first day.
- You can elect or increase accidental death and dismemberment for you or your spouse directly in your **BenefitReady** Account.
- You must reduce or cancel your optional coverage directly in your **BenefitReady** Account.

For long term care insurance, you need to complete a separate enrollment form. Packets will be available at the open enrollment information sessions.

Employee Benefits will be available at all of the open enrollment information sessions to assist you in completing your forms or answering questions. You can also contact Employee Benefits by telephone at (651) 266-6500.

If you do not make changes to your OPTIONAL insurance coverages in your BenefitReady Account by October 16, 2015, your current optional life, disability, and accidental death and dismemberment coverages will remain the same in 2016.

Life and Long Term Disability Claims

Employee Benefits, (651) 266-6500, can assist you with the proper forms you need to complete in order to claim any life or disability benefits.

Short Term Disability Claim

The following questions and answers will help you file a claim by telephone with Standard Insurance Company (The Standard) should you become disabled. The steps outlined below will enable you to access their efficient claims services quickly and easily.

When should I report a Short Term Disability (STD) claim?

Report a claim as soon as you believe your absence from work may extend beyond seven calendar days for absences relating to a sickness. If your absence is related to an accident, please report this absence immediately. You may report a claim up to four weeks in advance of a planned disability absence, such as childbirth or scheduled surgery.

What number do I call to initiate the claim process?

Please call The Standard's Disability Claim Reporting Service at 800.378.2395 to report a claim.

What are the hours of operation for the Disability Claim Reporting Service?

The Standard's customer service benefits examiners are available Monday through Friday between 7:00 a.m. and 7:00 p.m., Central Time. If you call outside these hours, you may leave a detailed voicemail message, including your name and phone number, and a customer service representative will call you the following business day during business hours. Please identify yourself as an employee of the City of Saint Paul.

When I call to report my claim, what questions will I be asked?

You will be asked to provide the following information:

- Employer: City of Saint Paul
- Group Number: [Policy # 148318B]
- Name and Social Security Number
- Last day at work
- Nature of claim/Medical Information
- Physician information*

* Within one business day of filing a claim, The Standard will fax an Attending Physician's Statement (APS) to your doctor for completion. The Standard will make up to three follow up attempts to obtain a completed APS from your doctor. Although The Standard will be following up with your doctor, we encourage you to contact your doctor and ask their assistance in completing the APS on your behalf. You will be responsible for providing any necessary authorizations to your doctor to release this information to us.

Who is responsible for notifying the City of Saint Paul of my absence?

It is your responsibility to follow the normal City of Saint Paul absence reporting procedures by notifying your manager or supervisor of your absence. The Standard will notify the City of Saint Paul of your intent to file an STD claim.

Will I receive a confirmation from The Standard after I initiate a claim?

After initiating an STD claim, The Standard will send you a letter confirming receipt of your claim. In addition, The Standard will include our Attending Physician's Statement (APS), Fraud Notices and an Authorization to Obtain Information form for you to sign and return, where applicable.

Where do I send the completed forms?

Completed forms may be mailed to:

Standard Insurance
Company Employee
Benefits Division P.O. Box
2800
Portland, OR 97204

Or if you prefer, you may fax completed forms to The Standard. Our toll-free Fax number is 800.378.6053.

How long does it normally take for a claim decision?

Once The Standard receives a completed claim application, it will take approximately one week to make a claim decision. If a decision has not been made within one week, you will be notified with details.

If my claim for STD benefits is approved, how long will it take to receive my first check?

STD benefit payments are paid in arrears on a weekly basis. In most cases, STD checks are mailed on Wednesday of each week. STD benefit payments that are payable for retroactive claims will be mailed following claim approval. STD checks will be mailed directly to your residence.

Whom should I call with questions about my claim?

For general questions about your claim, please call The Standard's toll-free Disability Benefits number, 800.368.2859. A knowledgeable customer service benefits examiner will be happy to assist you.

CONTINUATION OF BENEFITS

CONTINUATION OF BENEFITS

Under federal and/or state regulations, you may continue your participation in the City's group health insurance plan, dental insurance, the health flexible spending account, VEBA/HRA, and some life insurance coverages. The method and duration of continuing coverage are dependent upon the circumstances under which eligibility for coverage is lost (the "qualifying event"). Qualifying events:

- ◆ Dependent's loss of eligibility for dependent status
- ◆ Divorce or legal separation of employee
- ◆ Major/substantial reduction in hours worked of employee which results in a loss of benefits
- ◆ Unpaid leave of absence of employee
- ◆ Death of employee
- ◆ Employee's termination of employment for a reason other than gross misconduct

If the qualifying event is leave of absence, see [pages 85 through 87](#). Otherwise, the federal and state COBRA laws require that the City offers continuation of coverage to the following qualified persons:

- ◆ An employee (and his/her covered dependents) whose coverage would otherwise end due to: (a) termination of employment for a reason other than gross misconduct; or, (b) a discontinuance of the employee's pay (i.e., layoff, suspension, or leave of absence); (c) loss of benefit eligibility (i.e., significant reduction of hours worked, or change in title or bargaining unit disallowing benefits);
- ◆ An employee's surviving spouse and/or children whose coverage would otherwise end due to the employee's death;
- ◆ An employee's spouse and/or children whose coverage would otherwise end due to divorce or legal separation;
- ◆ An employee's spouse and/or children whose coverage would otherwise end due to the employee's election to drop out of the health plan upon the employee's entitlement to Medicare; and,
- ◆ An employee's child whose coverage would otherwise end due to ceasing to be a dependent child under the generally applicable requirements.

Exception: Continuation is not available to any employee, spouse, ex-spouse, or dependent that becomes covered under any other group health plan, except as may otherwise be provided by law.

Notice Requirements

The employer is responsible to give qualified persons written notice of their continuation rights, obligations, and costs when a qualifying event occurs. If a qualified dependent ceases to be eligible for coverage due to divorce or the loss of dependent status, notice must be provided to the employer within 60 days of the event.

Election Requirements

Continued coverage is not automatic. The qualified person must elect to continue any or all of the eligible benefits in which s/he was enrolled. The period during which continuation coverage can be elected:

- ◆ Must begin no later than the date coverage would otherwise end due to a qualifying event; and,
- ◆ Must be within 60 days of the qualifying event date or such other period as required by state law; and,
- ◆ May not end earlier than 60 days, or such other period as required by state law, after the coverage ends, due to a qualifying event, and after the qualified beneficiary receives notice of his or her continuation rights.

Failure to return the election form within the stated 60 day period will result in termination of eligibility. Your initial contribution will include the cost of coverage, retroactive to the date of the qualifying event, and is payable at the time of election. If an election is made during the qualifying 60 day period after the qualifying event, the plan shall permit payment for continuation coverage 45 days after the date of the election. If full payment for the original contribution is not received within 45 days of the date of your election to continue coverage, your coverage will be terminated for non-payment, effective the end of the month in which the qualifying event took place.

Monthly Premium

A person who elects continuation will be required to pay the entire cost of the continued coverage plus a 2% COBRA administration charge when applicable. Failure to pay the monthly premium will result in cancellation of coverage.

Continuation Period

Continued coverage will end on the earliest of the following dates:

- ◆ For qualified persons described above (pertaining to termination of employment or discontinuance of pay or loss of benefit eligibility), the date coverage has been continued for 18 months; or, for all other qualified persons, the date coverage has been continued for 36 months or such other period as required by state law.
- ◆ With respect to each qualified person, the date that person becomes covered under any other group health plan as a result of employment or re-employment.
- ◆ The end of the period for which contribution is paid; if the required contribution is not paid on a timely basis (required payments are the responsibility of the qualified person).
- ◆ The date the City plan is terminated, if ever.

Leaves of Absence/Layoff/Suspension

If you take a voluntary leave under the Civil Service Rules, or experience a layoff or suspension, or take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993, the way in which you may participate in the plan will depend on whether or not you continue to receive compensation from the City. If, during a leave, you continue to be paid by the City, your benefit elections can remain in effect and the City will continue to pay its portion of your premiums and withhold your contributions. If you are not being paid by the City your participation

in the plans will be treated in the same way as if you had terminated employment (see above). You may elect to continue to pay for your health insurance, some life insurance, and any health care expense reimbursement benefits on an after-tax basis. If you continue coverage, your prior benefit election will be reinstated when you return to work. If you do not continue your benefits, they will not be reinstated upon your return to work. You will be canceled and your next opportunity to reinstate will be during open enrollment for the following year.

If you take a voluntary leave under the Civil Service Rules, or experience a layoff or suspension, or take a leave of absence that is a family or medical leave under the Family and Medical Leave Act of 1993, you should contact Employee Benefits to discuss your continued participation in the benefit plans during your absence. In general, if you take an unpaid family or medical leave, you may continue to participate in the benefit plans, provided you continue to pay your portion of premiums and contributions on an after-tax basis during the leave by sending your payment to CieloStar after you receive the monthly premium due notice.

If you receive taxable pay from the City during your leave, you will continue to pay for your benefits on a pre-tax basis through contributions from that pay.

In addition, if you are on a family or medical leave under the Family and Medical Leave Act at any point during the plan year, you will be entitled to revoke your election with respect to medical coverage and any medical expense reimbursement benefits under the plan. In addition, following your return from the family or medical leave, you will be entitled to reinstate those coverages for the remainder of the plan year, on the terms that applied prior to the leave. However, if you reinstate medical reimbursement coverage under the health care flexible spending account following a family or medical leave:

- ◆ Your period of coverage for the plan year will exclude periods for which your coverage had lapsed because of the revocation or termination;
- ◆ No expenses incurred during the excluded period will be eligible for reimbursement under the plan;
- ◆ Your level of coverage for the plan year of the reinstatement will equal your coverage level in effect at the time of your revocation or termination, reduced on a pro rata basis to reflect excluded periods for which your coverage had lapsed; and
- ◆ All previously paid benefits will be charged against your revised coverage level.

For example, assume that Stacey elected \$1,200 of medical reimbursement coverage for the plan year and was paying for this benefit on a pre-tax basis. On April 1, Stacey began a family/medical leave that extended through May. Through March 31 reimbursable medical expenses in the amount of \$400 were incurred. Stacey revoked her election on April 1 and reinstated the coverage on June 1. Because Stacey revoked the election rather than continuing it and paying for the coverage any medical expenses incurred from April 1 through May 31 would not be eligible for reimbursement. Upon reinstatement, the period of coverage for the plan year will be January through March and June through December, unless there is an earlier termination under the rules that apply to all participants. Because of this two-month lapse, upon reinstatement, Stacey's election for the plan year will be adjusted from \$1,200 to \$1,000.

Because Stacey has already received \$400 of benefits, Stacey will be eligible for up to \$600 of additional reimbursement for the plan year.

Any revocation or request for reinstatement in the City's group health insurance or health care account must be made using the group insurance application. In the case of a revocation, the application must be submitted no later than 30 days after the commencement of the family and medical leave. In the case of a request for reinstatement, the form must be submitted no later than 30 days after return from the family or medical leave. If the employee continues on unpaid leave after the expiration of either FMLA or Voluntary Leave, the expected duration of the leave will determine whether the City will continue to bill the employee for the full premium or whether CieloStar will be notified to offer COBRA election.

If you take a military leave of absence you may have a right to have your coverage continued under group health plans, including the medical expense reimbursement portion of this plan. Upon your return from a military leave of absence, you may have a right to reinstate your coverage.

Please contact Employee Benefits as soon as you know you will be taking a family or medical leave, military leave, or going on layoff or suspension.

Retirement Planning

As you plan for retirement:

- Read your bargaining union contract; City contributions towards insurance vary by union.
- Contact Benefits at 651-266-8892 to request the "Steps to Retirement" document and schedule a meeting to get signed up for insurance after retirement.
- Call PERA at 651-296-7460; you must be collecting your PERA retirement in order to be eligible for a City contribution towards retiree insurance.
- Sign your separation of employment with your department Payroll specialist; the City requires you to sign this in order to be eligible for a City contribution towards retiree insurance.

Benefits staff can answer any questions you might have about your benefits after retirement. Retirees under age 65 are offered the same plans as active employees, but City contributions are different. Other health insurance plans are available for retirees over age 65.

The meeting with Benefits will go over your options for retiree health insurance, explain COBRA continuation, provide information on the Post Employment Health Plan for those eligible for severance pay, and get you signed up for automatic withdrawal of premium payments.

DEFERRED COMPENSATION

DEFERRED COMPENSATION

As a City employee, you can participate in a 457 Deferred Compensation plan. Under a deferred compensation plan, you can make pre-tax contributions bi-weekly through payroll deduction into a variety of investment options to save for retirement. By setting aside a portion of your income to accumulate on a tax-deferred basis, you pay less tax dollars now, and your savings and investment earnings accumulate tax-deferred until you start drawing from the plan at retirement. The City of Saint Paul offers employees a choice of two deferred compensation plans:



Voya Financial is an American financial, retirement, investment and insurance company based in New York, New York. In April 2014, the company (formally known as ING) rebranded itself as Voya Financial.



Minnesota State Deferred Compensation Plan, Administered by
Minnesota State Retirement System

Both plans offer a wide range of investment options, each designed to pursue a different investment objective. Contact plan representatives for:

- ◆ Information describing the plan, its options and investment histories
- ◆ Help with enrollment or change forms
- ◆ Catch-up rules
- ◆ Emergency withdrawal or Payout information

How Deferred Compensation Works

You decide how much of your salary you want to defer (as little as \$10 per pay period or as much as the maximum of \$18,000.)

- ✓ Complete the appropriate participation/enrollment materials.
- ✓ If you're age 50 or over, you can contribute the maximum of \$24,000. If you are eligible for catch-up you can contribute the maximum of \$36,000. In the last quarter of 2015, the IRS will announce the cost-of-living increase adjustment for 2016 maximum deferrals.
- ✓ The City will deduct those contributions from your paycheck before State or Federal income taxes are taken out, and forward them to the deferred compensation plan administrator on a regular basis.
- ✓ You choose how to invest your contributions from the investment options offered under the plan.

- ✓ Contributions and earnings accumulate tax-deferred. You are subject to State and Federal income taxes only when you receive benefit payments.
- ✓ The plan has no effect on Social Security or PERA. Your Social Security and PERA benefits are based on your total pay, including the amounts paid into the deferred compensation
- ✓ You can change your deduction amount or stop and start your deductions whenever you choose.
- ✓ You can change your allocation and investment options within the plan whenever you choose.
- ✓ You can't actively contribute to both plan (VOYA and MNDCP) at the same time, but you can have assets invested in both plans at once.
- ✓ Employer matching contributions may be deposited per your bargaining unit contract.
- ✓ Withdrawals from a deferred compensation plan are generally only allowed when you retire; separate from City employment; in the event of an "unforeseeable emergency or hardship" as defined by the Internal Revenue Code; or death.

Eligibility

The deferred compensation plans are available to all City employees, even those not eligible for insurance.

Reasons to Enroll

By deferring compensation, you have the opportunity to:

- ✓ Lower your current income taxes because you postpone paying taxes on contributions and investment earnings until you withdraw them (when you may be in a lower tax bracket).
- ✓ Enjoy the advantage of tax-deferred compounding.
- ✓ Accumulate more for retirement than you would with an after-tax retirement savings plan.

The Power of Saving

To show how contributing toward retirement on a before-tax basis affects your paycheck, let's assume you earn \$30,000 in taxable income annually and you want to defer \$100 from each paycheck to a deferred compensation plan, and you're in a 30% combined State and Federal tax bracket. You are paid every other week – 26 times a year.

	PAYCHECK BEFORE JOINING PLAN	PAYCHECK AFTER JOINING PLAN
Income After Adjustments	\$1,154.00	\$1,154.00
Def Comp Contribution	\$0.00	-\$100.00
Net Taxable Income	\$1,154.00	\$1,054.00
Income Tax (30%)	-\$346.00	-\$316.00
Take-home Pay	\$808.00	\$738.00

With deferred compensation, your current State and Federal income tax is reduced, so it only costs you \$70 out-of-pocket to invest \$100. Now, see how the \$100 bi-weekly contributions could accumulate over a long period of time:

	AFTER-TAX SAVINGS	DEFERRED COMPENSATION
Biweekly Contribution	\$100.00	\$100.00
Less Income Tax (30%)	-\$30.00	\$0.00
Net Biweekly Contribution	\$70.00	\$100.00
Net Yearly Contribution	\$1,820.00	\$2,600.00
After 5 Years	\$10,271.00	\$15,449.00
After 15 Years	\$39,889.00	\$67,508.00
After 25 Years	\$87,677.00	\$169,917.00
After 30 Years	\$121,640.00	\$253,767.00

The above information assumes an annual effective interest rate of 7% and a 30% combined Federal and State tax bracket. These amounts are for illustration purposes only, and do not represent the performance of any investment options. Savings totals do not reflect fees or expenses associated with the deferred compensation plan.

Roth 457

The Roth 457 (b) option gives you the opportunity to make contributions on an after-tax basis. Note that any City matching funds will by law be on a pre-tax basis.

Contributions you make to your 457(b) plan apply to your combined traditional 457(b) and Roth (after-tax) 457(b). In 2016, you can potentially contribute up to \$18,000 and maybe more if you are eligible under one of two catch-up provisions.

- ✓ Under the regular 3 year catch-up provision, you may be eligible to contribute up to \$36,000.
- ✓ Under an age 50-plus catch-up, you would be eligible to contribute up to \$24,000.

Distributions from your traditional 457(b) are taxed as ordinary income in the year in which the money is distributed; while distributions from your Roth 457(b) account may be tax-free for federal income tax purposes (check your state tax rules). However, all distributions must be qualified and meet the following criteria:

1. The funds must be held for a 5-year holding period, dating from the earlier of:
 - The first year that you contribute to any Roth 457(b) account in your employer's plan,
 - If you make a direct rollover contribution to your Roth 457(b) from which the direct rollover originated, or
 - The first year of a Roth in-plan conversion

AND

2. The distribution must be made on or after you have reached age 59½ (assuming you have separated from service), are disabled, or made to your beneficiary after your death.

Plan Comparison

If you are interested in the deferred compensation plans, you can receive a complete plan-to-plan comparison at any open enrollment session from either VOYA or MNDCP representatives. The plan-to-plan comparison includes information on rate of returns, individual operating expenses, and total fund expenses.

The comparison information below provides an overall comparison of the plan features provided by VOYA and the MNDCP. Specific questions should be directed to the plan representatives.

	VOYA	MNDCP
Local Plan Administrator	VOYA 100 Washington Ave, Suite 1700 Minneapolis, MN 55401	Minnesota State Retirement System 60 Empire Drive, Suite 300 St Paul, MN 55103
Local Representative Phone Numbers	Mark Isenberg 612/492-0209 or Michael Stein 612/492-0213 8:00 a.m. to 4:30 p.m.	(651) 247-6638 8:00 a.m. to 4:30 p.m.
National Representative Phone Numbers	(800) 262-3862 Mon-Fri 7:00 a.m. to 9:00 p.m. Sat 7:00 a.m. to 3:00 p.m.	(800) 657-5757 Mon-Fri 8:00 a.m. to 4:30 p.m.
Automated Telephone Voice Response System	(800) 262-3862 24 hours a day - 7 days a week	(877) 457-6466 (option 1) 24 hrs a day - 7 days a week
E-mail Questions	www.voyaretirementplans.com	www.mndcplan.com
Website Investment Options	www.voyaretirementplans.com	www.mndcplan.com
	43 Investment options 42 Variable funds 1 Fixed interest account	13 Investment options 11 Variable funds 6 Retail mutual funds 1 Fixed interest accounts
Quarterly Account Statements	Yes; mailed to home.	Yes; mailed to home.
Financial Planning Services	Available at an extra charge.	Not available at this time.
Enrollment	Personal one-on-one service with a local representative. Can be done any time during the year at the work site on employee time, or at a location and time convenient for the employee, including at home in the evening.	Personal one-on-one service with a local representative. Can be done any time during the year at the work site on employee time.
Annual Account Fees Daily	None	None
Asset-Based Charges	Daily asset charge applies to the entire variable fund balance as follows: 0.45% on VOYA funds; 0.45% on non-VOYA funds.	Daily asset charges are capped on balance in excess of \$100,000. 0.07% annual maximum of \$70.
Fund Operating Expenses	0.34% to 1.15%	0.01% to 1.27%
Expenses: Load, Risk & Mortality, Annuity	None.	None.
Purchase, Transaction Fees, Surrender Charges		
Fee for Minimum Distribution	None.	None.
Compensation for Reps	Commission	Salary

Enrollment

You can enroll or cancel participation in a deferred compensation plan any time during the year. You can change your deduction amount or stop and start your deductions whenever you choose. To enroll or make changes, contact a plan representative for the appropriate forms to complete.

The deferred compensation program is meant for long-term savings only. It should not be considered for short-term needs. Do not participate if you cannot afford to leave invested money untouched until retirement, or if you do not have other savings set aside for emergencies.

Moving Assets From One Plan to Another

You may enroll in either the VOYA or Minnesota Deferred Compensation Plan any time during the year. The assets remain tax-deferred. You must complete two forms; one to transfer assets out of the plan, and the other to transfer assets into the other plan. Some of the fixed funds may have restrictions on the amount you may transfer. Forms are available from VOYA and MNDCP representatives.

Website

	VOYA	MNDCP
Web Address	www.voyaretirementplans.com https://demos.voyacdn.com/pwebdemo/	www.mndcplan.com
Capabilities	<ul style="list-style-type: none"> ◆ Current balance and contribution history ◆ Daily fund quotes and market updates ◆ Fund performance (including personal rate of return) ◆ Change investment elections (fund and allocation changes) ◆ Investment growth calculator ◆ Withdrawal request option ◆ Change contribution amount including the option to schedule future increases ◆ Update beneficiary information ◆ Plan information ◆ Order literature and prospectuses ◆ Asset allocation worksheet ◆ Links to educational workshops for Social Security, Retirement Healthcare, Life Insurance, College Planning and Retirement Readiest ◆ Interactive Retirement Readiest tool for contribution, allocation and age calculator. 	<ul style="list-style-type: none"> ◆ Current balance and contribution history ◆ Current fund allocation ◆ Daily fund quotes and market updates ◆ Fund performance ◆ Change investment elections (fund and allocation changes) ◆ Transfer rebalancer and dollar-cost averaging ◆ Download forms and plan materials ◆ Retirement income software (incorporates MNDCP, PERA, and Social Security) ◆ Withdrawal Quote System (provides retirement estimates and payout options) ◆ Links to PERA, Social Security, retail mutual funds, and the IRS

Payment Choices

You can start receiving payment from your deferred compensation plan as soon as 30 days from separation of employment. But, you don't have to withdraw funds until age 70½. All payments will be taxed as ordinary income in the year received, so you should discuss your income tax liability with an accountant or attorney before choosing an option. You can receive your benefits in any one of the following ways:

- ◆ Distribution over your lifetime.
- ◆ Distribution over your lifetime and the lifetime of your designated beneficiary.
- ◆ Distribution over a set period of time not extending beyond your life expectancy.
- ◆ Distribution over a set time period not extending beyond the joint and last survivor life expectancy of both you and your designated beneficiary.
- ◆ Lump sum or partial lump sum distribution in combination with one of the other options.
- ◆ An estate conservation option that allows you to receive only the minimum amount required by law at either age 70½ or retirement, whichever comes later.
- ◆ A systematic withdrawal option that provides periodic income for either a specific dollar amount or a specified time period at retirement or separation from service.

Death Benefit

Upon your death, your plan beneficiary will receive benefits according to options/time frames outlined in the plan. If you die before benefits commence and your plan beneficiary is also your spouse, he or she is not required to begin receiving payments any earlier than when you would have reached age 70½.

Emergency Withdrawal

Generally, withdrawals from a deferred compensation plan are not allowed unless you retire, separate from service, or die. However, a withdrawal can be made to meet an "unforeseeable emergency" as defined by the Internal Revenue Code. An unforeseeable emergency means a severe financial hardship to the participant resulting from:

- ◆ A serious illness or accident of the participant or beneficiary, the participant's or beneficiary's spouse or dependent.
- ◆ Major loss of the participant's or beneficiary's property due to casualty.
- ◆ Similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the participant or the beneficiary. This does not include the purchase of a home or car, or payment of college expenses.

Emergency withdrawals are processed by each deferred compensation provider. Contact your plan administrator for an application.

IMPORTANT PHONE NUMBERS

IMPORTANT PHONE NUMBERS

City and County Credit Union (651) 225-2754	Your City and County Credit Union offers many services: savings, checking, ATM/debit cards, online services, VISA credit cards, car loans, personal loans, mortgages, and more.
HealthPartners BabyLine (800) 845-9297	If you're pregnant or up to six weeks postpartum, you can call the HealthPartners BabyLine service to speak with specially trained nurses about medications, breast-feeding, unfamiliar aches and pains, mood swings, or other pregnancy-related concerns. Available 365 days a year, 24/7.
HealthPartners CareCheck® Program (952) 883-5800 (800) 942-4872	You can call the CareCheck program 24 hours a day. You must notify CareCheck before hospitalizations or same day surgeries when using an out-of-network provider.
HealthPartners CareLine™ Service (800) 551-0859	The HealthPartners CareLine service offers skilled medical professionals who are specially trained to assess medical conditions of all kinds. When you call after regular clinic hours, a CareLine nurse might suggest home care, a visit to your clinic, a trip to an urgent care clinic or a visit to the emergency room, depending on your condition. Available 365 days a year, 24/7.
HealthPartners EAP/Management Line (866) 326-7194	HealthPartners EAP provides confidential counseling and referral services to you and your family at no cost, 24 hours a day, 7 days a week. HealthPartners EAP can help resolve relationship, mental health, legal, domestic issues, substance abuse, gambling, financial, or work concerns. HealthPartners EAP also offers the Management Line, a unique resource for managers and supervisors. The Management Line complements the City's internal resolution processes with an objective third-party perspective without replacing or infringing upon personnel policies or services.
HealthPartners Member Services (952) 883-5000 (800) 883-2177 Español 866-398-9119	HealthPartners can answer any questions you have about network providers, specific benefits provided through the City's group medical plan, or assist you with changing your primary medical or dental clinic choices.
Behavioral Health Navigators (888) 638-8787	A behavioral health navigator can match you with the network provider that best meets your behavioral needs. They can identify providers based on specialty, and on specific diagnostic, language, and cultural competence.
VOYA (612) 492-0209 or 0213 (800) 525-4225	VOYA is a City deferred compensation plan administrator. They can help you understand and enroll in the VOYA deferred compensation plan. This can be done anytime during the year; it is not limited to open enrollment.
MNDCP (651)296-2761 or (800)657-5757	Minnesota Deferred Compensation Plan is a City deferred compensation plan administrator. They can help you understand and enroll in the State of Minnesota Deferred Compensation Program. This can be done anytime during the year; it is not limited to open enrollment.
CieloStar Flexible Spending Accounts (612) 436-2778 (877) 491-5979 Fax: (612) 335-9217 (877) 491-6016	CieloStar can assist you in determining allowable expenses for reimbursement through the flexible spending accounts, and assist you with completing the reimbursement request (claim) form.
Employee Benefits (651) 266-6500	Employee Benefits staff are always available to answer questions or direct you to the appropriate resource. Most questions regarding benefit eligibility, negotiated employer contribution amounts, payroll deductions for insurance coverages, and specific information on rules for changing benefit elections should be directed to Employee Benefits.
Standard's Short Term Disability Claim Reporting Service (800) 378-2395	Report a claim as soon as you believe your absence from work may extend beyond seven calendar days for absences relating to a sickness. If your absence is related to an accident, please report this absence immediately. You may report a claim up to four weeks in advance of a planned disability absence, such as childbirth or scheduled surgery. The Standard's customer service benefits examiners are available Monday through Friday between 7:00 a.m. and 7:00 p.m. Central Time

**Use this Benefit Book for
reference throughout the year!**



EMPLOYEE ACKNOWLEDGMENT

EMPLOYEE ACKNOWLEDGMENT

1. I understand that employee pre-tax dollars spent are also excluded from income eligible for FICA (Social Security) deduction.
2. I understand that employee pre-tax dollars spent will reduce income eligible for deferred compensation contribution.
3. I understand that the IRS value of employee life insurance in excess of \$50,000 is taxable income and is subject to FICA deduction.
4. I understand that if I apply for coverages requiring evidence of insurability, and the coverage is subsequently denied, the selection will be stricken from csp.benefitready and I will not be allowed to re-select until the next open enrollment.
5. I understand that the following changes in status will require the completion of a change form:
 - a) A change in bargaining unit if the new bargaining unit offers different benefit options; and
 - b) A change from full time to part time status, and vice versa, if my bargaining unit agreement requires or allows an election change under these circumstances.
6. I understand that if I do not print and save a copy of my benefit election statement, I will not be able to dispute an enrollment election that differs from what I intended.
7. I understand that no mid-year changes may be made to my elections for medical and dental insurance unless they are allowed by plan rule, federal law, and provider contract.
8. I understand that if I currently have a medical plan and do not enroll at csp.benefitready by the deadline I will retain my current medical plan.
9. I understand that if I currently carry no medical and I do not enroll on csp.benefitready by the deadline, I will have no medical coverage in the following year.
10. I understand that if I fail to re-enroll in a flexible spending account for 2016 by the deadline, my participation will be terminated at the end of the 2015 plan year per IRS regulations.



Go onto csp.benefitready.com to elect benefits.