2024 | 2025

EMPLOYEE BENEFIT GUIDE

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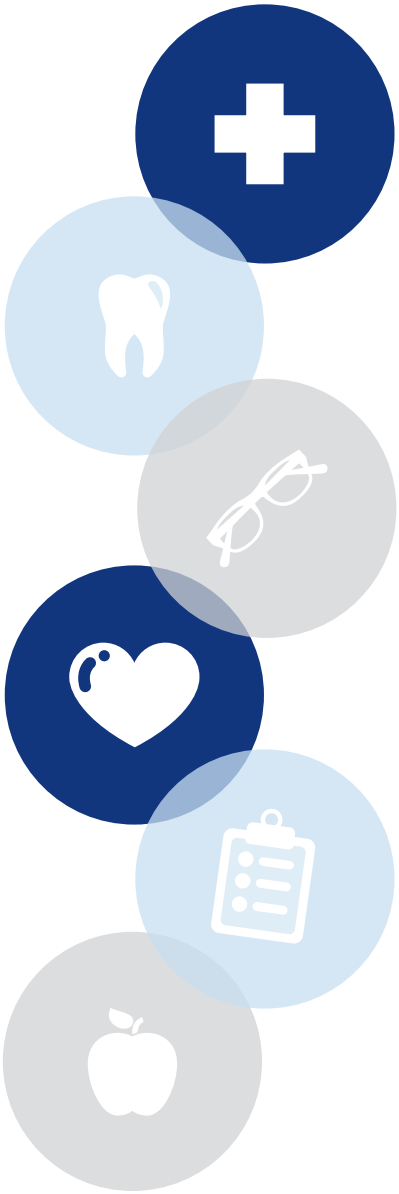


This booklet is merely a summary of benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Delray Beach reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

Contact Information

	Human Resources	Alexa DeFranco Benefits Manager	Phone: (561) 243-7377 Email: defrancoa@mydelraybeach.com
		B.J. Clay Benefits Specialist	Phone: (561) 243-7154 Email: clay@mydelraybeach.com
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) www.mybentek.com/delraybeach
	Employee Health Center	Employee Health and Wellness Center	Phone: (561) 243-7612
	Medical Insurance	Cigna Healthcare Group Number: 3344500	Customer Service: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Cigna/Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
HRA	**Health Reimbursement Account**	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Telehealth	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.mycigna.com
	Dental Insurance	Solstice Group Number: 14058	Customer Service: (877) 760-2247 www.solsticebenefits.com
	Vision Insurance	EyeMed Group Number: 1007691	Customer Service: (866) 939-3633 www.eyemed.com
FSA	**Flexible Spending Accounts**	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Basic Life and AD&D Insurance	The Standard	Customer Service: (800) 628-8600 www.standard.com
	Voluntary Life Insurance	The Standard	Customer Service: (800) 628-8600 www.standard.com
	Employee Assistance Program	Cigna EAP - Civilian	Customer Service: (877) 622-4327 www.mycigna.com | Employer ID: delraybeach
		Cigna EAP - Emergency Responders	Customer Service: (877) 505-3671 www.mycigna.com | Employer ID: delraybeach
	Short Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Long Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Supplemental Insurance	Allstate	Customer Service: (800) 521-3535 www.allstatebenefits.com
		Trustmark	Customer Service: (800) 918-8877 www.trustmarksolutions.com
		LegalShield	Customer Service: (800) 654-7757 www.shieldbenefits.com/delraybeach
		Pet Assure	Customer Service: (800) 891-2565 www.petassure.com

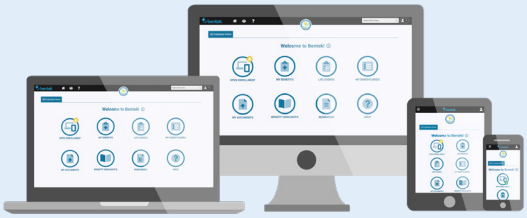
Introduction

The City of Delray Beach provides group insurance benefits to eligible employees. The Employee Benefit Guide provides a general summary of the benefit options as a convenient reference. Please refer to the City of Delray Beach Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact the City's Benefits Manager using the contact information provided.

Online Benefit Enrollment

The City of Delray Beach provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Life Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report qualifying life events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/delraybeach**
  Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com, Monday through Friday during regular business hours 8:30am - 5:00pm.

To access Bentek using a mobile device, scan code.

Group Insurance Eligibility

The City's group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective 31 days following the date of hire. For example, if employee is hired on April 15, then the effective date of coverage will be May 16.

Separation of Employment

If employee separates employment from the City, insurance for medical, dental and vision will continue through the end of month in which separation occurred. Other coverage may terminate on the last date of employment. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse/domestic partner and/or dependent child(ren) of the participant or spouse/domestic partner. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to the age of 18 months) of a covered dependent (Florida State Statute)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Dental and Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

Please see Taxable Dependents if covering eligible over-age dependents.

Disabled Dependents

Coverage for a dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group's insurance plans; and
- The dependent has been continuously insured.

Proof of disability will be required upon request. Please contact the Benefits Manager if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under employee's medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, imputed income must be reported on the employee's W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare taxes. Imputed income is the dollar value of insurance coverage attributable to covering each adult dependent child. Contact the Benefits Manager for further details if covering an adult dependent child who will turn age 27 any time during the upcoming calendar year or for more information.

Please Note: *There is no imputed income if adult dependent child is eligible to be claimed as a dependent for Federal income tax purposes on the employee's tax return.*

Group Insurance Eligibility *(Continued)*

Domestic Partner Coverage

Domestic partners may be eligible to participate in the City's group insurance plans if the partner is officially registered as a domestic partner with the City. Once the partner is officially registered as a domestic partner with the City, the employee must submit the following documents to the Benefits Manager:

- Domestic Partnership Certificate of Registration issued by the Palm Beach County Clerk and Comptroller's Office or County of residence, where available; and
- Certification of Dependent Children of a Domestic Partnership; and
- Agreement to notify the City of the termination of the Domestic Partnership.

The completed documents must be submitted at the time of enrollment. Covered employee may elect coverage for employee's qualifying domestic partner and eligible dependent(s) of the domestic partnership. IRS guidelines state; employee may not receive a tax advantage on any portion of premiums paid, related to domestic partner coverage. Employees insuring domestic partners and/or child dependent(s) of a domestic partner will see the insurance premium deductions on a post-tax basis and any amount subsidized by the City will be reported as "imputed income" to the employee. Employee may contact the Benefits Manager for further details and rates if the employee is covering a domestic partner at any time during the upcoming plan year.

Documentation Requirements

All dependents must have an established legal relationship to employee to be covered under the benefit program. Dependent documentation copies are stated in the the table below. Proof of Social Security Cards may be requested.

Employee with dependent(s) enrolled in the group insurance plans is advised that employee will be required to comply with this process or continued coverage for such dependent(s) may be jeopardized. Dependents cannot be enrolled in coverage until this information is provided. Once this information is received, coverage will be retroactively provided and employee will be responsible for any missing employee payroll premium contributions.

Dependent Relationship	Documentation Required
Spouse	• *Copy of legal government issued marriage certificate*
Dependent child(ren) under age 26	• *Copy of State issued birth certificate(s)* ***OR*** *copy of legal guardianship court documents listing employee as legal guardian*
Step-child(ren) under age 26	• *Copy of State issued birth certificate(s)* • ***AND*** *the appropriate dependent child documentation listed above*
Child(ren) under legal guardianship or custody under age 26	• *Copy of court documents showing legal guardianship* ***OR*** *legal custody*
Child(ren) adopted or in the process of adoption under age 26	• *Copy of court documents of the legal adoption showing relationship to and placement in employee's house* ***OR*** *adoption certificate*
Child(ren) age 26-30	• *Copy of State issued birth certificate(s) or legal guardianship court documents, listing employee or spouse as parent/ legal guardian* • ***AND*** *Overage Dependent Affidavit signed by employee*

Please Note: *Religious documents and registration cards are not acceptable proof. Employee may "black out" financial information.*

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Flexible Spending Accounts (FSA), and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the Open Enrollment Period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

Please Note: *The forming of a Domestic Partnership, in and of itself, is not considered a Qualifying Event.*

IMPORTANT NOTES

If employee experiences a Qualifying Event, the **Benefits Manager must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes may be effective the date of the Qualifying Event or the first of the month following the Qualifying Event. Newborns are effective on the date of birth. Qualifying Events will be processed in accordance with employer and carrier eligibility policy. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided as a supplement to this booklet being distributed to new hires and existing employees during the Open Enrollment period. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	Benefits Manager
Address:	80 Depot Avenue, Suite 1 Delray Beach, FL 33444
Phone:	(561) 243-7377
Email:	defrancoa@mydelraybeach.com
Website:	www.mybentek.com/delraybeach

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Benefits Manager.

If there are any questions about the plan offerings or coverage options, please contact the Benefits Manager at (561) 243-7377.

Employee Health and Wellness Center

The Employee Health and Wellness Center is available to all employees and dependents (spouses, domestic partners, and child(ren) two (2) years and over) enrolled in the City's medical plan.

Employee utilization of the Health and Wellness Center is completely voluntary and private. Employee's medical information will not be shared with the City. The Employee Health and Wellness Center can help lower out-of-pocket costs and improve employee health with short wait times and no co-pays or deductibles. All services and generic prescription medications received at the Employee Health and Wellness Center are provided at no charge.

The Employee Health and Wellness Center provides the care that employee and family member(s) need for all non-emergency illnesses, at no cost.

Available Services include:

- ✓ Primary Care
- ✓ Well Woman Visits
- ✓ Prescription Dispensing
- ✓ School Physicals
- ✓ Annual Adult Physicals
- ✓ Telehealth Services
- ✓ Labs Performed On-Site
- ✓ EKG's
- ✓ Health Risk Assessments
- ✓ Maintenance Drugs
- ✓ Acute Illness
- ✓ X-Rays & Ultrasounds

The Employee Health and Wellness Center hours of operation are:

Hours of Operation

Monday	8:00 a.m. – 5:00 p.m.
Tuesday	8:00 a.m. – 5:00 p.m.
Wednesday	7:30 a.m. – 5:00 p.m.
Thursday	8:00 a.m. – 5:00 p.m.
Friday	8:00 a.m. - 1:30 p.m.

To schedule an appointment, contact (561) 243-7612.

Employee Health and Wellness Center
80 Depot Avenue, Suite 2, Delray Beach, FL 33444 | Phone: (561) 243-7612

Medical Plan Resources

Cigna Healthcare offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other medical plan resources, please contact Cigna's customer service at (800) 244-6224 or visit www.mycigna.com.

The myCigna Mobile App

The myCigna mobile app is an easy way to organize and access important health information. Anytime. Anywhere. Download it today from the App Store℠ or Google Play™. With the myCigna mobile app, members can:

- Quickly view, print, email, or share ID Cards from mobile device
- Search for a doctor, pharmacy, or health care facility, from Cigna's national network and compare quality-of-care ratings and costs
- View and search recent and past claims
- View and refill prescriptions
- View plan coverage and authorizations
- Review plan deductibles and maximums
- View wellness goals and awards

Telehealth

Cigna provides access to telehealth services as part of the medical plan. MDLIVE is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is required and should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telehealth, such as:

- ✓ Sore Throat
- ✓ Headache
- ✓ Stomachache
- ✓ Fever
- ✓ Cold and Flu
- ✓ Allergies
- ✓ Rash
- ✓ Acne
- ✓ UTIs and More

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact MDLIVE through Cigna.

MDLIVE | Customer Service: (888) 726-3171 | www.mycigna.com

Medical Insurance - Cigna OAPIN Core Plan

The City offers medical insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Cigna's customer service.

Medical Insurance – Cigna OAPIN Core Plan

(Salary Under $60,000)

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	With Completed Incentive	Without Completed Incentive
Employee Only	$0.00	$0.00
Employee + Spouse	$87.70	$100.86
Employee + Child(ren)	$70.24	$80.78
Employee + Family	$148.81	$171.13

Medical Insurance – Cigna OAPIN Core Plan

(Salary Above $60,000)

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	With Completed Incentive	Without Completed Incentive
Employee Only	$0.00	$0.00
Employee + Spouse	$95.68	$110.03
Employee + Child(ren)	$76.62	$88.12
Employee + Family	$162.34	$186.69

Cigna Healthcare | Customer Service: (800) 244-6224 | www.mycigna.com

Cigna OAPIN Core Plan At-A-Glance

Network	Open Access Plus
Plan Year Deductible (PYD)	**In-Network**
Single	$1,500
Family	$3,000
Coinsurance	
Member Responsibility	20%
Plan Year Out-of-Pocket Limit	
Single	$3,000
Family	$6,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$40 Copay
Premium Tier 1 Specialist	$50 Copay
Non-Premium Tier 1 Specialist	$65 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab** *(Bloodwork)**	No Charge
X-rays**	No Charge
Advanced Imaging** *(MRI, PET, CT)*	No Charge
Outpatient Surgery in Surgical Center	20% After PYD
Physician Services at Surgical Center	20% After PYD
Urgent Care *(Per Visit)*	$50 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	20% After PYD
Outpatient Hospital *(Per Visit)*	20% After PYD
Physician Services at Hospital	20% After PYD
Emergency Room *(Per Visit; Waived if Admitted)*	$500 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	20% After PYD
Outpatient Services *(Per Visit)*	20% After PYD
Outpatient Office Visit	$40 Copay
Prescription Drugs *(Rx)*	
Generic	$20 Retail Copay
Preferred Brand Name	$50 Retail Copay
Non-Preferred Brand Name	$75 Retail Copay
Mail Order Drug *(90-Day Supply)*	2x Retail Copay

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Cigna Open Access Plus network.

Plan References

**LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.*

***Costs may differ if services are received at a hospital facility.*

Important Notes

*Services received by providers or facilities **not** in the Open Access Plus network, will not be covered.*

Medical Insurance - Cigna OAPIN Buy-Up Plan

The City offers medical insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Cigna's customer service.

Medical Insurance – Cigna OAPIN Buy-Up Plan

(Salary Under $60,000)

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	With Completed Incentive	Without Completed Incentive
Employee Only	$31.78	$36.55
Employee + Spouse	$182.94	$210.37
Employee + Child(ren)	$154.98	$178.23
Employee + Family	$280.83	$322.95

Medical Insurance – Cigna OAPIN Buy-Up Plan

(Salary Above $60,000)

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	With Completed Incentive	Without Completed Incentive
Employee Only	$31.78	$36.55
Employee + Spouse	$199.56	$229.50
Employee + Child(ren)	$169.07	$194.43
Employee + Family	$306.36	$352.31

Cigna Healthcare | Customer Service: (800) 244-6224 | www.mycigna.com

Cigna OAPIN Buy-Up Plan At-A-Glance

Network	Open Access Plus
Plan Year Deductible (PYD)	**In-Network**
Single	$750
Family	$1,500
Coinsurance	
Member Responsibility	20%
Plan Year Out-of-Pocket Limit	
Single	$2,500
Family	$5,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$40 Copay
Premium Tier 1 Specialist	$50 Copay
Non-Premium Tier 1 Specialist	$65 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab** *(Bloodwork)**	No Charge
X-rays**	No Charge
Advanced Imaging** *(MRI, PET, CT)*	No Charge
Outpatient Surgery in Surgical Center	20% After PYD
Physician Services at Surgical Center	20% After PYD
Urgent Care *(Per Visit)*	$50 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	20% After PYD
Outpatient Hospital *(Per Visit)*	20% After PYD
Physician Services at Hospital	20% After PYD
Emergency Room *(Per Visit; Waived if Admitted)*	$300 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	20% After PYD
Outpatient Services *(Per Visit)*	20% After PYD
Outpatient Office Visit	$40 Copay
Prescription Drugs *(Rx)*	
Generic	$20 Retail Copay
Preferred Brand Name	$40 Retail Copay
Non-Preferred Brand Name	$65 Retail Copay
Mail Order Drug *(90-Day Supply)*	2x Retail Copay

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Cigna Open Access Plus network.

Plan References

**LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.*

***Costs may differ if services received at a hospital facility.*

Important Notes

*Services received by providers or facilities **not** in the Open Access Plus network, will not be covered.*

Medical Insurance - Cigna OAP Choice Fund Plan (with HRA)

The City offers medical insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Cigna's customer service.

Medical Insurance – Cigna OAP Choice Fund Plan (with HRA)

(Salary Under $60,000)

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	Additional HRA Funding with Completed Wellness Incentives
Employee Only	$12.02	$250
Employee + Spouse	$75.32	$500
Employee + Child(ren)	$59.66	$500
Employee + Family	$119.33	$500

Medical Insurance – Cigna OAP Choice Fund Plan (with HRA)

(Salary Above $60,000)

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	Additional HRA Funding with Completed Wellness Incentives
Employee Only	$12.02	$250
Employee + Spouse	$90.38	$500
Employee + Child(ren)	$71.53	$500
Employee + Family	$143.08	$500

Cigna Healthcare | Customer Service: (800) 244-6224 | www.mycigna.com

Cigna OAP Choice Fund Plan (with HRA) At-A-Glance

Network	Open Access Plus	
HRA Funding		
Employee/Employee+Dependent	$500/$1,000	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network***
Single	$1,500	$3,000
Family**	$3,000	$6,000
Coinsurance		
Member Responsibility	10%	40%
Plan Year Out-of-Pocket Limit		
Single	$3,000	$9,500
Family**	$6,000	$19,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	10% After PYD	40% After PYD
Specialist Office Visit (Premium Tier 1/Non-Premium)	10% After PYD/20% After PYD	40% After PYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)****	10% After PYD	40% After PYD
X-rays	10% After PYD	40% After PYD
Advanced Imaging *(MRI, PET, CT)*	10% After PYD	40% After PYD
Outpatient Surgery in Surgical Center	10% After PYD	40% After PYD
Physician Services at Surgical Center *(Tier 1 Providers/Non-Tier 1 Providers)*	10% After PYD/20% After PYD	40% After PYD
Urgent Care *(Per Visit)*	10% After PYD	40% After PYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After PYD	40% After PYD
Outpatient Hospital *(Per Visit)*	10% After PYD	40% After PYD
Physician Services at Hospital *(Tier 1 Providers/Non-Tier 1 Providers)*	10% After PYD/20% After PYD	40% After PYD
Emergency Room *(Per Visit)*	10% After PYD	10% After INN-PYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After PYD	40% After PYD
Outpatient Services/Office Visit *(Per Visit)*	10% After PYD	40% After PYD
Prescription Drugs *(Rx)*		
Generic	$20 Retail Copay	Not Covered
Preferred Brand Name	$40 Retail Copay	
Non-Preferred Brand Name	$60 Retail Copay	
Mail Order Drug *(90-Day Supply)*	2x Retail Copay	

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Cigna Open Access Plus network.

Plan References

***Out-Of-Network Balance Billing:** *For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the plan's Summary of Benefits and Coverage document.*

***Individual deductible and out-of-pocket limit does not apply if enrolled in the Family Plan.*

****LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.*

Health Reimbursement Account

The City provides employees who participate in the Cigna Choice Fund OAP HRA Plan, a Health Reimbursement Account (HRA) through Cigna Healthcare. The City's HRA benefits are administered by Cigna. HRA monies are funded by the City and can be used for any qualified medical expenses such as copayments, deductibles and coinsurance for physician services, hospital services, prescription drugs, etc.

If out-of-network providers are used at any time during the year, employee may incur expenses that exceed the Cigna HRA funded amount. Annual funding for the City provided HRA funds resets each October 1st.

2024-2025 HRA Funding Allotment

Employees enrolled in the City's medical plan will be funded $500 for Employee Only coverage or $1,000 for Employee + Dependent coverage for the plan year. HRA amounts will be prorated for new hires eligible outside the City's annual Open Enrollment Period.

Funds not used in any given plan year, up to $500, can be rolled over to the next plan year period, up to an accumulated cap of $1,000 for Employee Only and $2,000 for Employees with Family. This funding is in addition to any awarded Wellness Incentive monies earned.

Employee has an opportunity to earn additional monies to be placed in employee's HRA by participating in the City's Wellness Initiative Program. The City will award an additional $250 for Employee Only coverage or $500 for Employee + Dependent coverage.

Please Note: *The plan year deductible exceeds the HRA funding amounts. Members will be responsible for any amount over the HRA funding until the plan year deductible and out-of-pocket limit have been met for the plan year.*

How to Check Available HRA Balance

Balance, activity and account history is available anytime online at www.mycigna.com or by contacting Cigna at (800) 244-6224.

Retain Receipts

During the year, employee should keep all receipts and documentation for prescriptions and medical related expenses if needed to verify a claim for Cigna or for IRS tax purposes. If asked to produce documentation, a valid Explanation of Benefits (EOB) and receipt of payment for the services rendered will be sufficient.

What is the difference between an HRA and an FSA?

Health Reimbursement Account (HRA)

- ✓ Employer funded account
- ✓ Enrollment is automatic if enrolled in medical plan
- ✓ Funds used for eligible medical expenses for employee and dependent(s) enrolled in the Choice Fund OAP HRA medical plan
- ✓ Employees may carry over $500 of unused HRA Funds into the next year with a cap of $1,000 for Employee Only and $2,000 for Employee with Family

Flexible Spending Accounts (FSA)

- ✓ Employee funded accounts
- ✓ **Employee must enroll annually**
- ✓ Health Care FSA funds can be used for eligible medical, dental and vision expenses
- ✓ Employee may carry over $640 of unused Health Care FSA funds into the next plan year
- ✓ Dependent Care FSA funds may be used to pay for work-related day care expenses

If employee has the HRA and also elects an FSA, the HRA funds will be used first, then FSA funds will be used.

Cigna Healthcare | Customer Service: (800) 244-6224 | www.mycigna.com

Wellness Incentive Program

The City is committed to encouraging healthy behaviors. The City offers employee's enrolled in one (1) of the Cigna Healthcare medical plans the opportunity to reduce the employee monthly premium. Employees enrolled in the Cigna OAP Choice Fund Plan (with HRA) have an opportunity to also earn additional contributions into the HRA.

To receive the Wellness Incentives from the City, employee must participate in the following programs:

Cigna OAPIN Core and Cigna OAPIN Buy-Up Plans

When an employee enrolls in the Cigna OAPIN Core and Buy-up Plans, participation in the Wellness Incentive Program provides the employee the opportunity to receive reduced medical insurance premium payroll deductions. The employee will be required to complete the biometric screening through the City's employee Health and Wellness Center and complete the MyCigna online Health Risk Assessment (Wellness > My Health Assessment).

Cigna OAP Choice Fund Plan (with HRA)

When an employee enrolls in the Cigna OAP Choice Fund Plan (with HRA), participation in the Wellness Incentive Program provides the opportunity to earn additional HRA funding. The City will award an additional $250 for employee only coverage or $500 for employee plus dependent coverage. In order to receive reduced medical insurance premium payroll deductions and the additional HRA funding, the employee will be required to complete the biometric screening through the City's employee Health and Wellness Center and complete the MyCigna online Health Risk Assessment (Wellness > My Health Assessment).

To complete this program:

1. Employee must call the City's Employee Health and Wellness Center at (561) 243-7612 to schedule their annual biometric screening.
   - The biometric screening will include a finger stick and immediate review of the results. Based on these results, employee may be educated on additional health coaching opportunities and programs that are available to help improve his or her health.
2. Employee will also need to complete the online Health Risk Assessment on the Cigna website www.mycigna.com.
   - To complete the Health Risk Assessment, log onto www.mycigna.com. If employee has not registered, then employee will need to register by providing a user name and password. Once registered and/or logged in, click on Wellness and click on My Health Assessment. Employee will need the results of the biometric screening provided by the Employee Health and Wellness Center to complete the assessment.

Please Note: *To receive any Wellness Incentives from the City, employee must participate in the biometric screenings through the Employee Health and Wellness Center AND complete the Health Risk Assessment. If employee does not participate in both, employee will not receive the medical insurance premium reduction and additional funding to the Cigna OAP Choice Fund Plan (with HRA).*

For additional information concerning the Wellness Incentive Program, please contact the Benefits Manager.

Dental Insurance

Solstice DHMO S200B Plan

The City offers dental insurance through Solstice to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Solstice's customer service.

Dental Insurance – Solstice DHMO S200B Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$4.84
Employee + Spouse	$8.87
Employee + Child(ren)	$9.80
Employee + Family	$13.83

In-Network Benefits

The DHMO S200B plan is an in-network only plan that requires all services be received by a Primary Dental Provider (PDP). Employee and dependent(s) may select any participating dentist in the Solstice S200B network to receive covered services.

The DHMO S200B plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following page. Please refer to the summary plan document for a detailed listing of charges and benefits.

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Solstice S200B provider. Solstice reimburses out-of-network services based on certain services listed in the plans Schedule of Benefits. When going out-of-network, the provider will require payment at the time of appointment. Solstice will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Benefit Maximum

There is no benefit maximum on in-network services. However, there are benefit reimbursement maximums for certain out-of-network services.

Solstice Wellness Rewards

Solstice offers a Wellness Rewards program to all enrolled employees and qualified dependents. Solstice Wellness Rewards allows members to earn points for routine dental care services. Employees must register at mysmile365.com/solstice to be eligible. To view reward, visit solsticebenefits.perkville.com. Once registered and eligible, employees can select their reward and redeem by emailing wellness@solsticebenefits.com their mailing address. For more detailed information, please refer to www.solsticebenefits.com.

IMPORTANT NOTES

- *Two (2) routine cleanings per calendar year (once every six (6) months) covered under the preventive benefit.*
- *Should a member need to see a specialist under this plan (Oral Surgeon, Periodontist, Orthodontist, etc.), member must be referred by their Primary Dental Provider.*
- *Waiting periods and age limitations may apply.*
- *A member **must** receive services from facilities and providers in the **S200B network** for benefits to be covered.*

Solstice | Customer Service: (877) 760-2247 | www.solsticebenefits.com

Solstice DHMO S200B Plan At-A-Glance

Network	S200B	
Calendar Year Deductible (CYD)	**In-Network Only**	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Class I Services: Diagnostic & Preventive Care	**Code**	**In-Network**
Routine Oral Exam	0120	No Charge
Routine Cleanings *(1 Every 6 Months; Adult/Child)*	1110/20	No Charge
Bitewing X-rays	0274	No Charge
Complete X-rays	0330	$35 Copay
Sealants *(1 Per Molar; Child to Age 16)*	1351	No Charge
Class II Services: Basic Restorative Care		
Fillings *(Amalgam; 3 Surfaces)*	2160	No Charge
Fillings *(Resin; 3 Surfaces, Posterior)*	2393	$80 Copay
Extractions *(Erupted Tooth or Exposed Root)*	7140	$10 Copay
Root Canal Therapy *(Molar)**	3330	$210 Copay
Surgical Removal of Tooth *(Erupted)*	7210	$25 Copay
Surgical Removal of Tooth *(Impacted)*	7240	$63 Copay
Full Mouth Debridement *(Deep Cleaning)*	4355	$35 Copay
Class III Services: Major Restorative Care		
Crowns *(Porcelain Fused to High Noble Metal)***	2752	$195 Copay
Bridges *(Porcelain Fused to High Noble Metal)***	6242	$195 Copay
Dentures *(Upper/Lower)***	5110/20	$210 Copay
Class IV Services: Orthodontia		
Benefit — Child	8070/8080	$1,800/$1,850 Copay
Benefit — Adults	8090	$1,950 Copay
Retention *(Child/Adult)*	8680	$300 Copay

Locate a Provider

To search for a participating provider, contact Solstice's customer service or visit www.solsticebenefits.com. When completing the necessary search criteria, select S200B network.

Plan References

**Excluding final restoration.*

***Copays for these services do not include the additional cost of precious (High Noble) metal, semi-precious (Noble) metal and material and laboratory fees. The additional cost of precious metal shall not exceed $145 per unit and $120 per unit for semi-precious metal.*

Dental Insurance

Solstice DPPO Plan

The City offers dental insurance through Solstice to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Solstice's customer service.

Dental Insurance – Solstice DPPO Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$16.33
Employee + Spouse	$32.28
Employee + Child(ren)	$35.68
Employee + Family	$51.72

In-Network Benefits

The DPPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Solstice PPO network. These participating dental providers have contractually agreed to accept Solstice's contracted fee or "allowed amount." This fee is the maximum amount a Solstice dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Solstice DPPO provider. Solstice reimburses out-of-network services based on what it determines as the Usual and Customary (U&C) Charge. The U&C is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between Solstice's U&C and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The DPPO plan requires a $50 individual or a$150 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the dental PPO plan will pay for each covered member is $1,500 for in-network and out-of-network services combined. All services, including preventive, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

Solstice Wellness Rewards

Solstice offers a Wellness Rewards program to all enrolled employees and qualified dependents. Solstice Wellness Rewards allows members to earn points for routine dental care services. Employees must register at mysmile365.com/solstice to be eligible. To view reward, visit solsticebenefits.perkville.com. Once registered and eligible, employees can select their reward and redeem by emailing wellness@solsticebenefits.com their mailing address. For more detailed information, please refer to www.solsticebenefits.com.

Solstice Benefit Booster Program

Solstice Benefit Booster program allows employee to carryover part of the unused annual maximum. Employee earns Benefit Boosters by submitting at least one (1) claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year ($750). Employee and covered dependent(s) may accumulate rewards up to the maximum carryover amount ($400), and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost for that year, but employee can begin earning rewards again the very next year. In addition, if employee stays in the PPO network employee will earn an Annual PPO Bonus of $100.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount.
Annual Carryover Amount	$400	Amount added to the following year's benefit maximum.
Annual PPO Bonus	$100	Additional bonus is earned if the covered member sees a PPO provider.
Maximum Carryover	$3,000	Maximum possible accumulation for benefit rollover and PPO bonus combined.

Solstice | Customer Service: (877) 760-2247 | www.solsticebenefits.com

Solstice DPPO Plan At-A-Glance

Network	Solstice PPO	
Calendar Year Deductible (CYD)	**In-Network and Out-of-Network Combined**	
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum	**In-Network**	**Out-of-Network***
Per Member *(Includes Class I Services)*	$1,500	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Year)*		
Bitewing X-rays *(1 Series of Films Per Year)*		
Complete X-rays *(1 Series Every 3 Calendar Years)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam or Composite)*	Plan Pays: 90% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions *(1 Per Tooth Per Lifetime)*		
Anesthetics		
Class III Services: Major Restorative Care		
Crowns *(1 Per Tooth Every 5 Years)*	Plan Pays: 60% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Bridges *(1 Per Tooth Every 5 Years)*		
Dentures		
Periodontal Services		
Endodontics *(Root Canal Therapy)*		
Oral Surgery		
Class IV Services: Orthodontia		
Lifetime Maximum	$2,000	$2,000
Benefit *(Children and Adults)*	Plan Pays: 50%	Plan Pays: 50% *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact Solstice's customer service or visit www.solsticebenefits.com. When completing the necessary search criteria, select Solstice PPO network.

Plan References

***Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Out-of-Network Benefits section on the previous page.*

Important Notes

- *Two (2) routine cleanings per calendar year (Once every six (6) months) covered under the preventive benefit.*
- *For any dental work expected to cost $300 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

Vision Insurance

EyeMed Vision Plan

The City offers vision insurance through EyeMed to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the carrier's summary plan document or contact EyeMed's customer service.

Vision Insurance – EyeMed Vision Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$2.36
Employee + 1 Dependent	$4.61
Employee + 2 or More Dependents	$6.61

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employee and covered dependent(s) may select any network provider who participates in the EyeMed Insight network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may choose to receive services from vision providers who do not participate in the EyeMed Insight network. When going out of network, the provider will require payment at the time of appointment. EyeMed will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

EyeMed | Customer Service: (866) 939-3633 | www.eyemed.com

EyeMed Vision Plan At-A-Glance

Network		Insight	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 Copay	Up to $40 Reimbursement
Eye Exam at PLUS Provider*		No Charge	Up to $40 Reimbursement
Contact Lens Fit and Follow-Up	Standard Lens	Up to $40 Copay	Not Covered
	Premium Lens	10% Off Retail Price	Not Covered
Frequency of Services			
Examination		Once Every 12 Months	
Lenses		Once Every 12 Months	
Frames		Once Every 24 Months	
Contact Lenses		Once Every 12 Months	
Lenses			
Single		$15 Copay	Up to $30 Reimbursement
Bifocal			Up to $50 Reimbursement
Trifocal			Up to $70 Reimbursement
Frames			
Allowance		$130 Retail Allowance 20% Discount Over $130	Up to $98 Reimbursement
Allowance at PLUS Provider*		$180 Retail Allowance 20% Discount Over $180	Up to $98 Reimbursement
Contact Lenses**			
Non-Elective; Medically Necessary *(Prior Authorization Required)*		No Charge	Up to $210 Reimbursement
Elective	Conventional	Up to $130 Allowance 15% Discount Over $130	Up to $110 Reimbursement
	Disposable	Up to $130 Allowance	Up to $110 Reimbursement

Locate a Provider

To search for a participating provider, contact EyeMed's customer service or visit www.eyemed.com. When completing the necessary search criteria, select the Insight network.

Plan References

**PLUS Provider: Additional cost savings available when choosing a designated PLUS Provider. To search for a PLUS Provider, visit www.eyemed.com. When completing the necessary search criteria, look for participating providers with the PLUS mark.*

***Contact lenses are in lieu of spectacle lenses.*

Important Notes

Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.

Flexible Spending Accounts

The City offers Flexible Spending Accounts (FSA) administered through Cigna. The FSA plan year is from October 1 to September 30.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employee to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. **Participating employee must re-elect the dollar amount to be deducted each plan year.** There are two (2) types of FSAs:

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,200. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note, if family income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- **A child under the age of 13, or**
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household.

Please Note: Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from the participant's paycheck for the Dependent Care FSA.

A sample list of qualified Health Care expenses eligible for reimbursement include, but not limited to, the following:

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

To contribute to an FSA in the 2024-2025 plan year, employee must log into Bentek and elect contribution amount for either the Health Care FSA and/or the Dependent Care FSA. If employee is currently enrolled in an FSA, coverage does not rollover to the new plan year, employee must make a new election.

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Employee may carry over up to $640 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed **(employee must re-enroll in the new plan year to retain rollover)**. Dependent Care funds cannot be carried over.
- The Health Care FSA and Dependent Care FSA both have a 90 day run out period at the end of the plan year to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year (October 1 to September 30).
- Employee can enroll in an FSA only during the Open Enrollment Period, New Hire Orientation, or Qualifying Life Events.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible in the employee FSA as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail, fax, online or through the mycigna mobile app. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. Cigna may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the City. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $50,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $38.46 based on a 26 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$50,000	$50,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$49,000	$50,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $9,628	- $9,825
After Tax Expenses	- $0	- $1,000
Spendable Income	$39,372	$39,175
Tax Savings	**$197**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the $640 carry over that may be allowed for the Health Care FSA.* ***This rule is known as "use-it or lose-it."***

Claims Mailing Address
PO Box 182223, Chattanooga, TN 37422 | Fax: (877) 823-8953

Cigna | Customer Service: (800) 244-6224 | www.mycigna.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides Basic Term Life insurance at no cost to all eligible employees through The Standard. The Basic Term Life insurance benefit amount is determined by employee classification listed on the table to the right.

Accidental Death & Dismemberment Insurance

Also, at no cost to the employee, the City provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit, partial benefits may also be payable.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- Reduces to 65% of the benefit amount at age 65
- Reduces to 50% of the benefit amount at age 70

Life Insurance Imputed Income

The IRS requires the imputed cost of employer paid Employee Basic Term Life insurance benefit in excess of $50,000 must be included as income and is subject to Federal, Social Security and Medicare taxes.

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek.

The Standard | Customer Service: (800) 628-8600 | www.standard.com

Class	Class Description	Benefit Amount
Class 1	City Manager, Assistant City Managers, City Attorney & Department Heads	$150,000
Class 2	Assistant Department Heads, Police Legal Advisors, Assistant City Attorney, Division Heads, Battalion Chiefs and Police Lieutenants all earning $75,000 or more annually	$100,000
Class 3	Assistant Department Heads, Police Legal Advisors, Assistant City Attorney, Division Heads, Battalion Chiefs and Police Lieutenants all earning less than $75,000 annually	$75,000
Class 4	P.B.A. employees who are subject to a collective bargaining agreement	$50,000
Class 5	I.A.F.F. employees who are subject to a collective bargaining agreement	$50,000
Class 6	S.E.I.U. employees who are subject to a collective bargaining agreement earning $25,000 or more annually	$50,000
Class 8	Employees earning $60,000 or more annually, excluding employees in the above classes	$75,000
Class 9	Employees earning between $40,000 and less than $60,000 annually, excluding employees in the above classes	$60,000
Class 10	Employees earning less than $40,000 annually, excluding employees in the above classes	$50,000

Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible employee may elect to purchase additional Life insurance on a voluntary basis through The Standard. This coverage may be purchased in addition to the Basic Term Life coverage. Voluntary Life insurance offers coverage for employee, spouse and/or child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $200,000.**

- Units can be purchased from one (1) to five (5) times employee's annual earnings up to the maximum of $500,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70
- Rates are subject to increase annually and are based on the employees age's bracket.
- Group coverage with the City will end upon termination.

Voluntary Spouse Life Insurance

New Hires may purchase Voluntary Spouse Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $50,000.**

- Employee must participate in the Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $5,000, up to a maximum of $200,000, not to exceed 100% of the employee's Voluntary Life coverage amount.
- Evidence of Insurability (EOI) forms will be required for approval of coverage over the guaranteed issue amount or if elected after initially being eligible to participate.
- Benefit amounts are subject to the following age reduction schedule based on the spouse's age:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70

Voluntary Employee Life Rate Table

Monthly Rates

Age Bracket *(Based on Employee Age)*	Employee/Spouse *(Rate Per $1,000 of Benefit)*
<25	$0.07
25-29	$0.06
30-34	$0.07
35-39	$0.13
40-44	$0.20
45-49	$0.33
50-54	$0.53
55-59	$0.86
60-64	$1.12
65-69	$1.76
70+	$3.11

Monthly Premium Calculation:
Elected Coverage ÷ $1,000 x Employee Rate (See Rate Table) x 12 Months ÷ 26 Annual Deductions = Per Pay Premium

Dependent Child(ren) Life Insurance

- Employee must participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- Coverage may be purchased for dependent child(ren) from birth through age 26 in the amount of $10,000.
- Employee cost to cover all eligible children is $0.83 per pay period.

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek.

The Standard | Customer Service: (800) 628-8600 | www.standard.com

Employee Assistance Program

The City cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Cigna. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members/domestic partners free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes six (6) visits with a specialist, per person, per issue, per year, online material/tools and webinars. EAP offers counseling services on issues such as:

- ✓ Child Care Resources
- ✓ Legal Resources
- ✓ Grief and Bereavement
- ✓ Stress Management
- ✓ Depression and Anxiety
- ✓ Work Related Issues
- ✓ Adult & Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor/manager will not receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

To Access Services

Employee and family member(s) must register and create a user ID on www.mycigna.com to access EAP services.

Cigna EAP - Civilian
Customer Service: (877) 622-4327 | www.mycigna.com
Employer ID: delraybeach

Cigna EAP - Emergency Responders Support Line
Customer Service: (877) 505-3671 | www.mycigna.com
Employer ID: delraybeach

Voluntary Short Term Disability

The City offers Short Term Disability (STD) insurance to all benefit-eligible full-time employees working a minimum of 30 hours per week through New York Life Group Benefit Solutions. The STD benefit pays employee a percentage of weekly earnings if employee becomes disabled due to an illness or non-work related injury.

Voluntary Short Term Disability (STD) Benefits

- STD provides a benefit of 60% of employee's weekly earnings, up to a benefit maximum of $1,000 per week.
- Employee must be disabled for seven (7) consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 8th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is eight (8) weeks.
- Employee deemed unable to return to work after the STD eight (8) week maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefits may be reduced by other income.
- Disability benefits may be taxable.

New York Life Group Benefit Solutions
Customer Service (800) 362-4462 | www.mynylgbs.com

Long Term Disability

The City provides Long Term Disability (LTD) insurance at no cost to all benefit-eligible employees through New York Life Group Benefit Solutions The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of $5,000 per month.
- Employee must be disabled for 60 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 61st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.
- Disability benefits may be taxable.

New York Life Group Benefit Solutions
Customer Service (800) 362-4462 | www.mynylgbs.com

Supplemental Insurance

Allstate

Allstate offers supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction. Allstate pays money directly to the employee, regardless of what other insurance plans employee may have. To learn more about these Allstate plans and/or to schedule a personal appointment, contact a local Allstate agent.

Available plans include:

- ✓ Group Accident Plan
- ✓ Group Supplemental Health Insurance

Allstate | Customer Service: (800) 521-3535 | www.allstatebenefits.com
Agent: Elliott Fink | Phone (561) 756-5555
Email: insurancerewards@me.com

Trustmark Voluntary Benefits

Trustmark voluntary insurance can help you fulfill your responsibilities and protect your family, finances and future. Plans pay cash benefits, directly to you, when life gets difficult and you need them most. Coverage is paid via simple payroll deduction, and available plans include:

- ✓ Universal Life Insurance with Long-Term Care Benefit
- ✓ Critical Illness Insurance
- ✓ Disability Income Insurance

Trustmark
Customer Service: (800) 918-8877 | www.trustmarksolutions.com
Agent: Arthur Hoffman | Phone: (954) 609-4924
Email: artiehoffman@bellsouth.net

LegalShield

The City offers employees the opportunity to participate in enhanced legal benefits through LegalShield. By enrolling in the legal plan, participant and family have direct access to a nationwide network of attorneys who will provide legal assistance, for a variety of situations. The plan provides assistance, but is not limited to the following benefits:

- ✓ IRS Audit Assistance
- ✓ Trial Defense
- ✓ Adoption
- ✓ Traffic Tickets
- ✓ Wills & Living Trusts
- ✓ Real Estate
- ✓ Contract Review

IDShield

The City also offers employees the opportunity to enroll in an identity theft plan through IDShield. IDShield, also offered through LegalShield, protects employee, spouse, and child(ren) and may be purchased separately, or at a reduced rate when bundled with the legal plan.

This benefit assists with, but is not limited to the following:

- ✓ 24/7 Monitoring (Credit, Social Security, Social Media, Dark Web, Financial Accounts, Username/Password, and more)
- ✓ High Risk Application and Transaction Monitoring
- ✓ Identity Threat and Credit Threat Alerts
- ✓ Complete Restoration by Licensed Investigators
- ✓ Free unlimited consultation with a US based licensed private investigator
- ✓ $1 Million Dollar Protection Policy to cover any losses or out-of-pocket expenses
- ✓ 24/7 Emergency Assistance

The costs per pay period for coverage are listed in the premium table below.

Legal Insurance

26 Payroll Deductions - Per Pay Period Cost

	LegalShield and ID Shield	LegalShield Only	IDShield Only
Employee Only	$11.50	$7.36	$4.13
Employee + Family	$14.26	$7.36	$8.75

LegalShield | Phone: (800) 654-7757
https://www.shieldbenefits.com/delraybeach
Agent: Kelley Rheault | Phone: (954) 214-0327
Email: kelley@akasolutionsinc.com

Supplemental Insurance *(Continued)*

Pet Assure and PetPlus

The City provides employees the opportunity to purchase pet discount insurance plans on a voluntary basis through Pet Benefit Solutions. Pet Assure is a veterinary discount program that provides a 25% discount on in-house medical services at participating veterinarians. Visit www.petbenefits.com/search for a complete list of local providers. Employee may enroll any pet regardless of age, health or type - no exclusions! Members also have access to ThePetTag, a lost pet recovery service.

PetPlus is a pet products, prescriptions and preventative discount plan that provides members-only savings on items such as: flea and tick products, food (including Rx), toys, treats and more. Members also have access to 24/7 pet telehealth powered by AskVet.

Employee can choose to enroll in Pet Assure or Pet Assure with PetPlus.

Pet Insurance – Pet Assure & Pet Plus

26 Payroll Deductions - Per Pay Period Cost

	Pet Assure	Pet Assure with Pet Plus
Common Illnesses	✓	✓
Surgeries & Hospitalization	✓	✓
X-rays	✓	✓
Wellness Visits	✓	✓
Dental Care	✓	✓
Spay/Neuter	✓	✓
Prescription Medications	—	✓
Flea & Tick Products	—	✓
Vitamins & Supplements	—	✓
Heartworm Preventive	—	✓
Specialty Rx Food	—	✓
One Pet	$4.16 (Any Pet)	$6.24 (Dog or Cat Only)
All Pets	$4.16 (Any Pet)	$8.09 (Dog or Cat Only)

Pet Assure and PetPlus ***(Through Pet Benefit Solutions)***
Customer Service: (800) 891-2565 | www.petbenefits.com/land/cod
Email: customercare@petbenefits.com

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctors' names and addresses or prescription medications.

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RISK strategies | GEHRING GROUP
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