City of Coconut Creek Florida

2024 | 2025 EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

	Human Resources and Risk Management	Main Office	Phone: (954) 973-6715
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) Email: support@mybentek.com app.mybentek.com/coconutcreek
	Medical Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Telehealth	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Cigna/Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
HSA	**Health Savings Account**	Cigna - HSA Bank	Customer Service: (800) 244-6224 www.mycigna.com
	Dental Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	Cigna Vision	Customer Service: (888) 353-2653 www.mycigna.com
FSA	**Flexible Spending Accounts**	Chard Snyder a WEX Company	Customer Service: (800) 982-7715 www.chard-snyder.com
	Employee Assistance Program	Cigna	Customer Service: (877) 622-4327 www.mycigna.com
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Voluntary Life Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Short and Long Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Supplemental Insurance	Aflac	KCI Financial Agent: Tracy Reeves Phone: (954) 270-7543 | Fax: (954) 272-7043 Email: tracyl_reeves@us.aflac.com
		Preferred Legal IdentityWorks℠	Agent: Brian Samuels Customer Service: (888) 577-3476 Email: bjs@preferredlegal.com www.preferredlegal.com
	Claims, Billing and Benefit Assistance	Gehring Group	Customer Service: (800) 244-3696 Email: coconutcreek@gehringgroup.com

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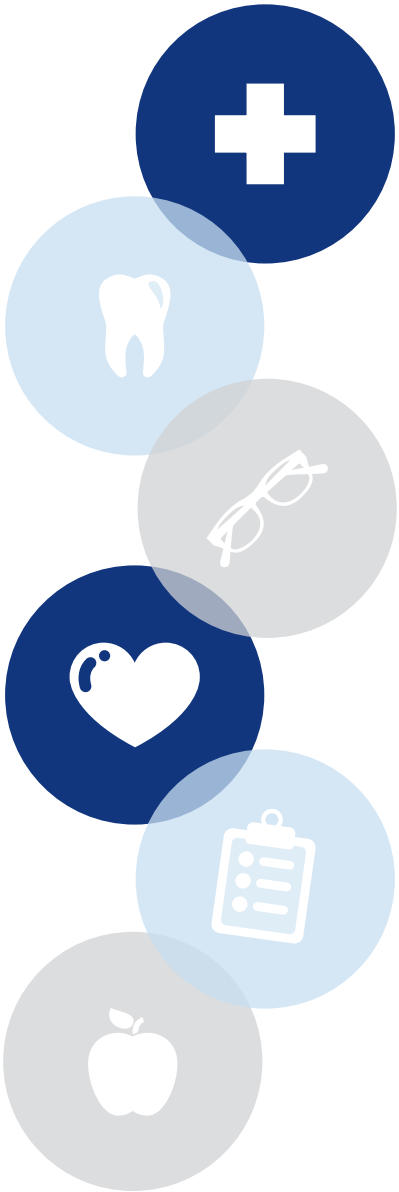


This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Coconut Creek reserves the right to amend, modify or terminate the plan at any time. This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

Introduction

The City of Coconut Creek provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the City of Coconut Creek's Civil Service Code, At-Will Employee Code, applicable Administrative Orders, applicable Collective Bargaining Agreements 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 Human Resources and Risk Management.

2024-2025 Plan Year News

The City of Coconut Creek will have the following plan options effective October 1, 2024 – September 30, 2025.

Medical Insurance — Cigna Healthcare is the City's medical insurance provider with two (2) plans to choose from:

- Open Access Plus In-Network Copay Plan *(OAPIN)*
- Open Access Plus Qualified High Deductible Health Plan *(OAP HDHP)*

Opt-Out Benefit — Employees who opt-out of the City's group medical insurance plan and who meet the Federal legislative requirements for a "conditional opt-out payment" shall continue to receive the opt-out payment, which is currently $153.85 bi-weekly ($4,000 annually). Those who enroll in individual or marketplace plans or do not otherwise meet the requirements for a "conditional opt-out" payment shall not be eligible for any opt-out payments.

To participate in the "conditional opt-out" benefit, employee is required to provide Human Resources and Risk Management with proof of current medical insurance indicating name of group insurance plan, name of employee and employee's tax dependents before the open enrollment deadline, September 16, 2024 (or by the designated deadline for new hires or qualifying event changes throughout the plan year). If an employee participates in the conditional opt-out, they would select "Conditional Opt-Out Payment" as their medical plan choice in Bentek.

Health Savings Account (HSA) — Employee enrolled in the Open Access Plus High Deductible Health Plan (OAP HDHP) will have a Health Savings Account automatically opened with HSA Bank. This is an interest bearing account and contributions can be payroll deducted throughout the year. Unlike a Flexible Spending Account (FSA), the funds in an HSA can roll over, earn interest and are portable from one employer to another.

Dental Insurance — Cigna Healthcare is the City's dental insurance provider with two (2) plan options available:

- DHMO Plan
- DPPO Plan

Limited Vision Plan — Employee covered by one of the City's medical plans receives one (1) routine vision exam from an in-network vision provider every 12 months at no charge. Cigna Healthcare offers a Limited Vision Plan through its Healthy Rewards Program, serviced by EyeMed, which is available to all members participating in the City's Cigna medical or dental plans.

Vision Buy-Up Plan — Cigna Healthcare is the City's vision insurance provider, offering a Buy-Up plan with enhanced vision benefits.

Please Note: Concurrent enrollment in both the Limited Vision Plan and the Vision Buy-Up Plan is prohibited.

Flexible Spending Accounts (FSA) — Chard Snyder is the City's Flexible Spending Account (FSA) administrator. Employee may elect an FSA for Health Care and/or Dependent Care. If employee has an existing FSA, employee must re-elect FSA and enter a contribution amount during Open Enrollment.

Employer Provided Plans

- **Employee Assistance Program (EAP)** - The Employee Assistance Program is provided to employees and their families at no cost through Cigna.
- **Basic Life and AD&D, Short Term Disability and Long Term Disability** - Is provided to employees at no cost through New York Life Group Benefit Solutions.

Voluntary Life Insurance — Voluntary Life insurance is available for the employee, spouse, and/or dependent child(ren) through New York Life Group Benefit Solutions. To enroll a spouse and/or dependent child(ren), you must enroll in Voluntary Employee Life insurance.

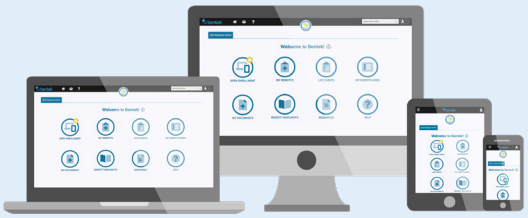
Voluntary Benefit Options

- Aflac *(various plans available)*
- Preferred Legal *(various plans available)*

Online Benefit Enrollment

The City 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 **app.mybentek.com/coconutcreek**
  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.

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:	Human Resources and Risk Management Dept.
Address:	4800 West Copans Rd. Coconut Creek, FL 33063
Phone:	(954) 973-6715
Website:	app.mybentek.com/coconutcreek

The SBC is only a summary of each 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 Human Resources and Risk Management Department or online at the above website address.

If there are any questions about the plan offerings or coverage options, please contact the Human Resources and Risk Management Department at (954) 973-6715.

Employee Wellness Committee

The City has a genuine interest in health, nutrition and overall well being of employees! We offer wellness programs and various events to benefit employee wellness throughout the year. We welcome new ideas and are actively seeking employee participation and assistance with the City Wellness initiative. Keep an eye out for the next wellness event/program and be a participant. Please contact the Human Resources and Risk Management Department for more information.

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 a full-time employee working a minimum of 30 hours per week. Coverage will be effective the first of the month following 30 days of full-time employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 1.

Separation of Employment

If employee separates employment from the City, insurance for medical and dental will continue through the end of month in which the 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 and/or dependent child(ren) of the participant or the spouse. 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

Please Note: *Domestic Partner coverage is not offered*.

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.

Disabled Dependents

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

- The dependent child 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 Human Resources and Risk Management Department 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 Human Resources and Risk Management Department 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.*

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.

Please Note: *Even though certain Aflac policies, including Aflac Short-Term Disability and Aflac Life (Term and Whole Life) are deducted post-tax, cancellation or enrollment of any Aflac policy(s) must be completed during the Open Enrollment Period.*

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: *Section 125 and COBRA Qualifying Events may differ. Should an active employee choose to terminate group insurance coverage through the City* ***solely*** *as a result of Medicare entitlement, covered dependent(s)* ***will not*** *be eligible for an extension of group insurance coverage through COBRA.*

IMPORTANT NOTES

If employee experiences a Qualifying Event, **employee must log on to Bentek 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.

Medical Plan Resources

Cigna 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.

Mobile App

Mobile app provides on-the-go access to the medical benefit account. Download the Cigna Healthcare mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View benefits
- Download member ID cards
- Locate a provider
- View claims

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

Headspace Care

Ginger is now Headspace Care! Stress impacts everyone – in and out of the workplace. Headspace behavioral health services offer coaching as a first level of support to build resilience of everyday stress producers through techniques and motivational interviewing to understand each members' needs and create a plan. Headspace behavioral health coaches are available on-demand via text-based chats, self-guided learning activities and content, and video-based therapy and psychiatry to help members reduce stress, reach goals and feel supported any time of the day or night. Members can work with a coach on:

- ✓ Achieving Goals
- ✓ Stress Management
- ✓ Building Self-Esteem
- ✓ Improving Communication
- ✓ Work Life Balance
- ✓ Recovering From Loss

Support is available anytime 24/7/365, on mobile devices, for a variety of mental health challenges – all from the privacy of any smartphone. Coaches can assist employee on understanding EAP benefits available to members and also may recommend adding a therapist or psychiatrist to the care team.

Headspace Care | organizations.headspace.com/connect

Cigna OAPIN Plan At-A-Glance

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	$1,000
Family	$2,000
Coinsurance	
Member Responsibility	20%
Calendar Year Out-of-Pocket Limit	
Single	$4,000
Family	$8,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance and Copays *(Does Not Include Rx)*
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$30 Copay
Specialist Office Visit *(No Referral Required)*	$50 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)**	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	20% *(Deductible Waived)*
Outpatient Surgery at Surgical Center	20% After CYD
Physician Services at Surgical Center *(Surgeons and Anesthesiologists)*	20% After CYD
Urgent Care *(Per Visit; Waived if Admitted)*	$75 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	20% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD
Physician Services at Hospital	20% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$200 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	20% After CYD
Outpatient Office Visit	$50 Copay
Outpatient Services	No Charge
Prescription Drugs *(Rx)*	
Calendar Year Out-of-Pocket Limit for Rx Costs	**Single:** $2,350 | **Family:** $4,700
Tier 1	$15 Retail Copay
Tier 2	$35 Retail Copay
Tier 3	$60 Retail Copay
Tier 4	$80 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 Open Access Plus network.

Plan References

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

Important Notes

- *There is a separate $2,350/$4,700 per calendar year, pharmacy out-of-pocket limit, that does not accumulate towards the medical calendar year out-of-pocket limit.*
- *Services received by providers and facilities **not** in the Open Access Plus network, will not be covered.*

Cigna OAP HDHP HSA Plan At-A-Glance

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 Open Access Plus network.

Plan References

***Out-Of-Network Balance Billing:** *For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.*

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

Important Notes

- *Once the calendar year deductible has been met, member pays 10% of eligible medical expenses; and, employee will be responsible for the Rx Copay, until the calendar year out-of-pocket limit has been met.*
- *Some services require pre-authorization. Failure to receive pre-authorization prior to receiving services may result in a 50% penalty.*

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$2,500	$5,000
Family	Per Person: $3,200 | Per Family: $5,000	Per Person: $5,000 | Per Family: $10,000
Coinsurance		
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Limit		
Single	$5,000	$10,000
Family	Per Person: $5,000 | Per Family: $10,000	Per Person: $10,000 | Per Family: $20,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	10% After CYD	30% After CYD
Specialist Office Visit	10% After CYD	30% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	10% After CYD	30% After CYD
X-rays	10% After CYD	30% After CYD
Advanced Imaging *(MRI, PET, CT)*	10% After CYD	30% After CYD
Outpatient Surgery at Surgical Center	10% After CYD	30% After CYD
Physician Services at Surgical Center	10% After CYD	30% After CYD
Urgent Care *(Per Visit)*	10% After CYD	10% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After CYD	30% After CYD
Outpatient Hospital *(Per Visit)*	10% After CYD	30% After CYD
Physician Services at Hospital	10% After CYD	30% After CYD
Emergency Room *(Per Visit)*	10% After CYD	10% After INN CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After CYD	30% After CYD
Outpatient Services	10% After CYD	30% After CYD
Outpatient Office Visit	10% After CYD	30% After CYD
Prescription Drugs *(Rx)*		
Tier 1	$15 Copay After CYD	30% After CYD
Tier 2	$35 Copay After CYD	30% After CYD
Tier 3	$60 Copay After CYD	30% After CYD
Tier 4	$80 Copay After CYD	30% After CYD
Mail Order Drug *(90-Day Supply)*	2x Retail Copay After CYD	30% After CYD

Health Savings Account

Employee who enrolls in the Cigna OAP HDHP will have a Health Savings Account (HSA) opened with HSA Bank. An HSA is an interest-bearing account where funds may be used to help pay employee and/or family deductible, coinsurance and any qualified health care expenses not covered by the plan.

- ✓ **2024 IRS Contribution Limitations:** $4,150 (individual coverage); $8,300 (family coverage)
- ✓ **2025 IRS Contribution Limitations:** $4,300 (individual coverage); $8,550 (family coverage)
- ✓ The HSA catch up contribution for individuals age 55 and older remains $1,000

An HSA is an interest-bearing account. Employee may opt to fund an HSA via pre-tax, evenly disbursed payroll deductions or a lump sum payroll deduction; this decision can be made and changed throughout the year by submitting an HSA Contribution Authorization form, which can be found on Coconet. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on an employee's tax return (making such contributions tax-free). This maximum HSA amount would include any employer and employee contributions (pre-tax or post-tax). If employee is receiving an employer contribution, employee will want to account for this towards the annual IRS total maximum so employee does not over-contribute for the tax year. Guidelines regarding the HSAs are established by the IRS. Employee should thoroughly review the enrollment materials before deciding to elect an HSA.

What to know about an HSA

- Employee owns the HSA funds from day one and decides how and when to spend the money.
- No use-it or lose-it rules; funds are in the account when needed, now or in the future. Participant cannot fund a traditional Health Care FSA, however, participant may fund a Limited Purpose FSA for dental and vision expenses only.
- HSA funds may earn interest.
- HSA dollars may be used tax-free for all eligible health care expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employee plan for retirement.
- An account holder may write a check or withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.
- Account holder can access HSA statement at any time to track account balance and activity online at www.mycigna.com.
- To be eligible to open an HSA, employee must be covered by a qualified high deductible health plan. Employee may not be covered under another medical plan that is not a qualified high deductible health plan including a plan the employee's spouse may have selected where he/she has family coverage. Please Note: Eligibility status to qualify for an HSA is specifically driven by employee and NOT dependents.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Over-age dependent is not able to use HSA funds for qualified expenses, even if dependent is covered under the medical plan as Federal law does not recognize them as a qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits The City from contributing HSA funds into the account. If employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts.
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare is eligible to enroll and contribute into the HSA up to the maximum contribution amounts. These funds can be utilized for the active employee and spouse expenses.
- Active employee ON Medicare and with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse may not contribute or receive HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

**Please contact the Human Resources and Risk Management Department for further information regarding funding variations towards employer HSA contributions.*

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

Dental Insurance

Cigna DHMO Plan

The City offers dental insurance through Cigna Healthcare to benefit-eligible employees. 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 Cigna's customer service.

In-Network Benefits

The DHMO plan is an in-network only plan that requires all services to be received by a Primary Dental Provider (PDP). Employee and dependent(s) may select any participating dentist in the Cigna Dental Care Access network to receive covered services. There is no coverage for services received out-of-network.

The DHMO 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

The DHMO plan does not cover any services rendered by out-of-network facilities or providers.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Benefit Maximum

There is no benefit maximum.

Mobile App

Mobile app provides on-the-go access to the dental benefit account. Download the Cigna Healthcare mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View benefits
- Download member ID cards
- Locate a provider
- View claims

IMPORTANT NOTES

- *Two (2) routine cleanings at no cost per calendar year are covered under the preventive benefit. Two (2) additional cleanings are available at the charge of a copay ($50 for adults/$40 for children).*
- *Referrals and prior authorizations are required to see a specialist (oral surgeon, periodontist, orthodontist, etc.) within the network.*
- *Waiting periods and age limitations may apply.*
- *Children under the age of 13 may visit a pediatric dentist. Contact Cigna for a list of pediatric dentists in the network. Once the child reaches age 13, a referral with approved medical reasons by Cigna will be required prior to being seen by a pediatric dental provider.*
- *Coverage and age limitations may apply to some services. Check the plan summary or contact Cigna prior to having services rendered.*
- *The summary is provided as a convenient reference and additional charges may apply. For a full listing of covered services, exclusions, and stipulations, refer to the plan's Schedule of Benefits or contact Cigna's customer service for details specific to a procedure.*

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

Cigna DHMO Plan At-A-Glance

Network	Dental Care Access	
Calendar Year Deductible (CYD)	**In-Network**	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Calendar Year Benefit Maximum	**In-Network**	
Per Member	Does Not Apply	
Class I Services: Diagnostic & Preventive Care*	**Code**	**In-Network**
Office Fee	N/A	$5 Copay
Routine Oral Exam *(4 Per Calendar Year)*	0150	$0 Copay
Routine Cleanings *(2 Per Calendar Year)*	1110/1120	$0 Copay
Bitewing X-rays *(2 Films)*	0272	$0 Copay
Complete X-rays *(1 Set Every 3 Years)*	0210	$0 Copay
Fluoride Treatments *(2 Per Calendar Year)*	1206	$0 Copay
Sealants - *Per Tooth*	1351	$11 Copay
Space Maintainers	1510	$30 Copay
Emergency Care to Relieve Pain *(During Regular Hours)*	9110	$6 Copay
Class II Services: Basic Restorative Care*		
Fillings *(Amalgam)*	2140	$0 Copay
Fillings *(Composite; Anterior)*	2330	$0 Copay
Fillings *(Composite; Posterior - 3 Surfaces)*	2393	$85 Copay
Simple Extractions	7140	$6 Copay
Surgical Extractions *(Soft Tissue)*	7220	$55 Copay
Root Canal Therapy* *(Excluding Final Restoration)*	3330	$275 Copay
Periodontal Maintenance *(Per Visit; 4 Per Calendar Year)*	4910	$35 Copay
General Anesthesia *(Each 15 Minute Increment)*	9223	$80 Copay
Repairs to Dentures*	5511/5512	$35 Copay
Class III Services: Major Restorative Care*		
Bridges*	5213/5214	$200 Copay
Crowns*	2752	$230 Copay
Dentures*	5110/5120	$185 Copay
Class IV Services: Orthodontia*		
Lifetime Maximum	None	None
Benefit — Child* *(Up to 19th Birthday)*	8670	$1,464 Copay
Benefit — Adult*	8670	$2,160 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 Dental Care Access network.

Plan References

** Additional charges may apply for some services. Please see plan summary or contact Cigna's customer service for details specific to procedure.*

Dental Insurance

Cigna Total DPPO Plan

The City offers dental insurance through Cigna Healthcare to benefit-eligible employees. 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 Cigna's customer service.

In-Network Benefits

The Total 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 Total Cigna DPPO network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna 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.

Please Note: *Total DPPO dental members have the option to utilize a dentist that participates in either Cigna's Advantage network or Total Cigna DPPO network. However, members that use the Cigna Advantage network will see additional cost savings from the added discount that is allowed for using a Cigna Advantage network provider. Members are responsible for verifying whether the treating dentist is an Advantage Dentist or a Total Cigna DPPO Dentist.*

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Total DPPO provider. Cigna reimburses out-of-network services based on what it determines as the Maximum Reimbursable Charge (MRC). The MRC 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 the Cigna's MRC 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 Total DPPO plan requires a $50 individual or a $150 family deductible to be met for in-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the Total DPPO plan will pay for each covered member is $2,000 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.

Progressive Plan

Cigna allows employee to earn an additional $150 (Maximum of $450) towards their calendar year benefit maximum for the following year. To qualify for the benefit, employee must receive at least one (1) Class I service during the calendar year.

- **Year 1:** $2,000 Benefit Maximum
- **Year 2:** $2,150 Benefit Maximum
- **Year 3:** $2,300 Benefit Maximum
- **Year 4:** $2,450 Benefit Maximum

Mobile App

Mobile app provides on-the-go access to the dental benefit account. Download the Cigna Healthcare mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View benefits
- Download member ID cards
- Locate a provider
- View claims

IMPORTANT NOTES

- *Four (4) routine cleanings per calendar year covered under the preventive benefit. Members can also receive additional cleanings at the charge of a copay.*
- *Late entrant provisions, age limitations and waiting periods may apply.*
- *For any dental work expected to cost $200 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.*
- *Teeth missing prior to coverage under the Cigna Total DPPO plan are not covered.*
- *The summary is provided as a convenient reference and additional charges may apply. For a full listing of covered services, exclusions, and stipulations, refer to the plan's Schedule of Benefits or contact Cigna's customer service for details specific to a procedure.*

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

Cigna Total DPPO Plan At-A-Glance

Network	Total Cigna DPPO	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	$100
Per Family	$150	$300
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$2,000**	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(4 Per Calendar Year)*		
Bitewing X-rays *(2 Per Calendar Year)*		
Complete X-rays *(1 Set Every 3 Calendar Years)*		
Emergency Care to Relieve Pain		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 100% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Oral Surgery		
Periodontal Services		
Anesthetics		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 60% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Dentures		
Bridges		
Implants		

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 Total Cigna DPPO 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.*

** *Cigna allows employee to earn an additional $150 (Maximum of $450) towards their calendar year benefit maximum for the following year, by obtaining a Class I preventive service.*

Vision Insurance

Cigna Vision Buy-Up Plan

The City offers vision insurance through Cigna Healthcare to benefit-eligible employees. 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 Cigna's customer service.

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 Cigna Vision serviced by EyeMed 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 Cigna Vision serviced by EyeMed network. When going out of network, the provider will require payment at the time of appointment. Cigna 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 Out-of-Pocket Maximum

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

Mobile App

Mobile app provides on-the-go access to the vision benefit account. Download the Cigna Healthcare mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View benefits
- Download member ID cards
- Locate a provider
- View claims

Cigna Healthcare
Customer Service: (888) 353-2653 | www.mycigna.com

Cigna Vision Buy-Up Plan At-A-Glance

Network	Cigna Vision Serviced by EyeMed	
Services	**In-Network**	**Out-of-Network**
Eye Exam	No Charge	Up to $45 Reimbursement
Retinal Imaging	Up to $39	Not Covered
Frequency of Services		
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses		
Single	$10 Copay	Up to $32 Reimbursement
Bifocal	$10 Copay	Up to $55 Reimbursement
Trifocal	$10 Copay	Up to $65 Reimbursement
Frames		
Allowance	Up to $130 Allowance + 20% Off Balance Over $130	Up to $71 Reimbursement
Contact Lenses*		
Non-Elective *(Medically Necessary)*	No Charge	Up to $210 Reimbursement
Elective	Up to $130 Allowance	Up to $105 Reimbursement

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 Vision Serviced through EyeMed network.

Plan References

**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 Chard Snyder a WEX Company. The FSA plan year is from October 1 to September 30; however, the annual maximum is based upon the calendar year.

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 the employee's paycheck and deposited into the FSA. During the year, the 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 three (3) types of FSAs:

- **Health Care FSA:** Available to eligible employee **not** enrolled in the Cigna OAP HDHP with an HSA. Covers medical, dental, and vision expenses that are not paid by insurance.
- **Limited Purpose FSA:** Available to eligible employee enrolled in the Cigna OAP HDHP with an HSA. A Limited Purpose Health Care FSA may be used for qualified dental and vision expenses.
- **Dependent Care FSA:** Covers day care expenses for qualified dependents necessary for employee and legal spouse, if married, to work.

Health Care FSA

This account allows participant to set aside up to an annual maximum of **$2,500**. 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 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

**These items are eligible expenses under the Limited Purpose FSA.*

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

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- The Health Care FSA allows a 2 1/2 month grace period at the end of the plan year. The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends. Once the grace period ends, any unused funds still remaining in the account will be forfeited.
- Employee can enroll in an FSA only during the Open Enrollment Period, New Hire Orientation or Qualifying 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 or via the Chard Snyder 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. Chard Snyder 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**	

Mobile App

Mobile app provides on-the-go access to the FSA benefit account. Download the Chard Snyder mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- File a claim
- View item for eligibility
- View account activity
- Upload receipts

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.* ***This rule is known as "use it or lose it."***

Claims Mailing Address
P.O. Box 2924, Fargo, ND 58108-2924

Chard Snyder a WEX Company
Customer Service: (800) 982-7715 | www.chard-snyder.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 employee and family members 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). The Human Resources and Risk Management Department will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor or manager. The referring supervisor or manager will not receive specific information regarding the referred employee's case. The referring supervisor or manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

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

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 New York Life Group Benefit Solutions. Eligible employee will receive a benefit amount of $20,000.

Accidental Death & Dismemberment Insurance

Also, at no cost to 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 70
- Reduces to 50% of the benefit amount at age 75

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

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

Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

Eligible employee may elect to purchase additional Life and AD&D insurance on a voluntary basis through New York Life Group Benefit Solutions. This coverage may be purchased in addition to the Basic Term Life and AD&D coverage. Voluntary Life and AD&D insurance offers coverage for the employee, spouse and/or dependent child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life and AD&D insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $130,000.**

- Units can be purchased in increments of $10,000 to a maximum of five (5) times salary or $500,000, whichever is less.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 70
  - Reduces to 50% of the benefit amount at age 75
- Voluntary Employee AD&D coverage matches the Voluntary Employee Life amount elected.

2024 Open Enrollment: Employees may enroll or increase coverage up to but not exceeding the Guaranteed Issue amount of $130,000, without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). All others will need to complete an EOI. Please contact Human Resources and Risk Management for additional information.

Voluntary Spouse Life and AD&D Insurance

New Hires may purchase Voluntary Spouse Life and AD&D insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $130,000.**

- Employee must participate in the Voluntary Employee Life and AD&D Plan for spouse to participate.
- Units can be purchased in increments of $10,000 to a maximum of $500,000 not to exceed 100% of the employee's Voluntary Life and AD&D Coverage insurance amount.
- Benefit amounts are subject to the following age reduction schedule, based on spouse age:
  - Reduces to 65% of the benefit amount at age 70
  - Reduces to 50% of the benefit amount at age 75
- Spouse rates are based on employee's age.
- Voluntary Spouse AD&D coverage matches the Voluntary Spouse Life amount elected.

2024 Open Enrollment: Employees may enroll or increase coverage for spouses up to but not exceeding the Guaranteed Issue amount of $130,000 without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). All others will need to complete an EOI. Please contact Human Resources and Risk Management for additional information.

Voluntary Dependent Child(ren) Life Insurance Only

- Employee must participate in Voluntary Employee Life and AD&D plan for dependent child(ren) to participate.
- Coverage may be purchased for dependent child(ren) birth to six (6) months in the amount of $1,000.
- Coverage may be purchased for dependent child(ren) age six (6) months up to the date in which the dependent child reaches age 26 in the amount of $10,000.
- Monthly cost for Voluntary Dependent Child(ren) Life coverage elected is $0.26 per month for any eligible child(ren) enrolled.

Life Insurance Imputed Income

Voluntary Life insurance elections may be subject to imputed income per IRS regulations. Please contact Human Resources and Risk Management for more information.

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

Short Term Disability

The City provides Short Term Disability (STD) insurance at no cost to all eligible employees 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.

Short Term Disability (STD) Benefits

- STD provides a benefit of 70% of employee's weekly earnings up to a benefit maximum of $1,500 per week.
- Employee must be disabled for 14 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 15th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 26 weeks.
- Employee deemed unable to return to work after the STD 26 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 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 66.67% of employee's monthly earnings up to a benefit maximum of $5,000 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 181st 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

Aflac

Aflac offers a variety of supplemental insurance plans that may be purchased separately on a voluntary basis. Premiums are paid via payroll deduction. Aflac pays cash directly to employee, regardless of what other insurance plans employee may have. Coverage is available for employee, spouse and children on most plans. Coverage is portable when employee retires or changes jobs, with no increase in premiums. To learn more about these plans and/or to schedule a personal appointment, contact Tracy Reeves. The following plans are available:

- ✓ Aflac Life, Term and Whole Life
- ✓ Critical Care and Recovery *(Plan 3)*
- ✓ Hospital Confinement-Choice
- ✓ Cancer Protection (Option 1, 2, 3)
- ✓ Short Term Disability Insurance *(Guarantee Issue)*
- ✓ Accident Indemnity Advantage - 24 Hour Protection

Aflac with KCI Financial
Local Agent: Tracy Reeves | Local Office: (954) 270-7543 | Fax: (954) 272-7043
Email: tracyl_reeves@us.aflac.com

Preferred Legal Plan

The City offers employees the opportunity to participate in a voluntary legal plan through Preferred Legal Plan. By enrolling in the legal plan, a participant will have 24-hour direct access to attorneys who will provide a variety of legal assistance and services such as those listed. Additional services may also be provided at discounted rates.

- ✓ Free unlimited legal advice via phone consultation
- ✓ Free face-to-face consultations with attorneys
- ✓ Free review of legal documents (real estate contracts, lease agreements, simple wills, etc.)
- ✓ Free letters and phone calls on employee's behalf
- ✓ Free Identity Theft information and restoration
- ✓ Free legal forms available through Preferred Legal Plan Form Library
- ✓ Notary services
- ✓ Free credit report analysis, repair and settling accounts in collection
- ✓ Free simple wills for employee and spouse

Preferred Identity Plan

The City offers employees the opportunity to participate in a voluntary identity protection plan through Identity Works℠, a part of Experian℠. By enrolling in the Preferred Identity Plan as an add-on benefit to the Preferred Legal Plan or as a stand-alone benefit, a participant will have the following benefits:

- Early warning Surveillance Alert™ notifications via email or mobile text
- Daily Bureau credit monitoring
- Dark Web internet monitoring
- Registration and protection of important personal data and information
- Monthly email notifications of "all clear" or other status
- $1,000,000 Identity Theft Insurance to cover items like illegal electronic fund transfers, loss wages, legal fees and private investigator costs
- Identity Theft Resolution Agents help resolve potential identity theft from start to finish
- A complete personal Experian credit report available daily so members can check for inaccurate information that may be a sign of past identity theft
- Additional resources so consumers can learn more about identity protection

Several level of coverage options may be purchased. The bi-weekly costs for each option are as follows:

Plan Type	Tier	Bi-Weekly Deduction
Legal Plan*	Not Applicable	$4.60
Identity Plan	Employee Only	$4.16
	Employee + Spouse	$8.31
	Employee + Family**	$10.62
Legal & Identity Plan Bundle***	Employee Only	$7.83
	Employee + Spouse	$11.06
	Employee + Family**	$13.36

**Legal Plan includes coverage for employee and household members.*

***Family plans include legal spouse and dependent children up to 18 years of age.*

****Rates shown for Legal & Identity Plan Bundle reflects discounted Identity Plan coverage bi-weekly rate (varied based upon coverage tier) plus Legal Plan coverage rate ($4.60 bi-weekly).*

Please Note: *All premiums will be deducted on a post-tax basis for the employees' convenience.*

Preferred Legal Plan | Identity Works℠, a part of Experian℠
Customer Service: (888) 577-3476 | www.preferredlegal.com
Agent: Brian Samuels | Email: bjs@preferredlegal.com

Claims, Billing & Benefit Assistance

If employees have questions on claims, receive bills from providers which they do not understand or would like general information on any of the employee benefits provided, please contact the Gehring Group Service Team.

The Gehring Group Service Team works directly with the City and its employees to provide claims and benefits service and will assist employees with their concerns. Please remember this is in addition to the City of Coconut Creek and is not replacing assistance employee may need from Human Resources and Risk Management.

Employee may contact a claims specialist by:

1. Email: coconutcreek@gehringgroup.com

Please include your name, contact information and a brief description of the issue. A Gehring Group Claims Specialist will respond via email or phone call to gather additional information.

OR

2. Call: (800) 244-3696

When calling, please identify yourself as an employee of the City of Coconut Creek and ask to speak to a Claims Specialist or another member of the City of Coconut Creek's designated team to assist with questions or concerns.

Office hours are Monday through Friday, 8:30am – 5:00pm. If calling after office hours, please leave a message indicating you are a City of Coconut Creek employee who would like to speak to a Claims Specialist. Please leave full name, contact information and a brief message and a Claims Specialist will be in contact with you the following business day.

At the Gehring Group, our goal is to be your advocate and ensure issues are resolved as quickly as possible.

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
A RISK STRATEGIES COMPANY

3500 Kyoto Gardens Drive
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970
www.gehringgroup.com

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