



EMPLOYEE AND FAMILY HEALTH CENTER
464 FERN STREET, WEST PALM BEACH, FL 33401
(561) 822-2000

7/1/2015 - 6/30/2016
Employee Benefit Highlights

GENERAL EMPLOYEES



City of West Palm Beach Employee Health Center

West Palm Beach Employee Health Center

464 Fern Street,
West Palm Beach,
FL 33401

Tel: (561) 822-2000
Fax: (561) 822-1588
www.cityfitmd.com



Monday - Thursday • 7:00 am - 6:00 pm,
Friday • 7:00 am - 4:00 pm,
Saturday • 8:00 am - Noon, Sunday • Closed
**(Hours subject to change)*



Stuart Urgent Care

3405 NW Federal Hwy,
Jensen Beach,
FL 34957

(772) 692-8082

www.stuarturgentcare.com

Mon. - Fri. • 8:30 am - 7:00 pm
Sat. • 8:30 am - 3:00 pm
Sun. • Closed
**(Hours subject to change)*

PLEASE NOTE - The above Employee Center telephone numbers are also an On-Call Medical Answering Hotline. This is available to members and their dependents 24 hours a day, 7 days a week in addition to the regularly scheduled hours.

CLOSED THE FOLLOWING HOLIDAYS (otherwise open regular hours):

- New Year's Day
- Independence Day
- Thanksgiving Day
- Memorial Day
- Labor Day
- Christmas Day

- ✓ **Services are 100% FREE**
- ✓ **24-Hour Medical On-Call Answering Service**
- ✓ **Primary Care and Urgent Care Services**
- ✓ **Wellness and Health Maintenance**
- ✓ **Chronic Disease Management**
- ✓ **Physicals**

- Wellness
- Well Woman
- DOT
- Preoperative
- School / Sports / Camp

- ✓ **On-Site Services**
- X-Ray
- Laboratory Draws*
- 12-Lead EKG
- IV Fluids
- ✓ **Medications Dispensed On Site****

* There may be specialty lab draws that must be drawn at an actual lab-draw station. Outside orders with uncommon lab requests must be provided to the health center so as to determine the capability of drawing such specimens.

** Providers may request lab studies and/or a provider/patient visit prior to the dispensing of any medications.

Rx Refill Line

Phone: 561.822.1585. Available for established patients.

Remember: upon visiting the Health Center, employees MUST provide a valid City ID Badge and show a current Cigna medical insurance ID card.

**In ALL Emergency
Situations,
Please Call 9-1-1.**



IMPORTANT CONTACT INFORMATION

City of West Palm Beach	Contact Name	Contact Information
Human Resources/Benefits Department	General Benefit Questions	Phone: (561) 494-1000
Health Center	Employee and Family Health Center	464 Fern Street West Palm Beach, FL 33401 Phone: (561) 822-2000 www.cityfitmd.com
	Prescription Refill Line	Phone: (561) 822-1582
Service	Provider	Contact Information
BenTek Online Enrollment	BenTek Technical Support	Email: support@mybentek.com Phone: (888) 5-BenTek (523-6835) www.mybentek.com/wpb
Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com On-Site Cigna Representative: (561) 494-1032
Prescription Drug Coverage & Mail-Order Program	Cigna Home Delivery	Customer Service: (800) 835-3784 www.mycigna.com
Health Reimbursement Account	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Dental Insurance	Humana	Customer Service: (800) 233-4013 www.compbenefits.com
Vision Insurance	Humana	Customer Service: (866) 537-0229 www.compbenefits.com
Flexible Spending Account (FSA)	WageWorks	Customer Service: (800) 950-0105 Mon. – Fri. 8:00am – 7:00pm CST www.takecarewageworks.com www.fsaworksforme.com/takecare
Basic & Voluntary Life and AD&D Insurance	The Hartford	Customer Service: (888) 563-1124 www.thehartfordatwork.com
Employee Assistance Program (EAP)	Aetna Resources for Living	24-Hour Crisis Line: (800) 272-7252 www.mylifevalues.com Login ID: CWPB Password: CWPB
Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 www.aflac.com Local City Aflac Representative: Linda Carcich (561) 784-5256 aflac@wpb.org (Lotus Note)
Preferred Legal Plan	Preferred Legal Plan	Customer Service: (888) 577-3476 www.preferredlegal.com Brian Samuels Email: info@preferredlegal.com
Defined Contribution and Deferred Compensation Programs	Empower Retirement (Great-West Retirement Services)	Customer Service: (800) 701-8255 www.gwrs.com On-Site Empower Retirement Representative: Helena Novakova Cell: (786) 877-9572 or On-Site HR (561) 494-1000 Email: Helena.novakova@empower-retirement.com

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Introduction

The City of West Palm Beach provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to the City's Personnel Policies, applicable Contracts and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If you require further explanation or need assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact the Human Resources/Benefits Department using the contact information provided.

Notices

COBRA Continuation of Medical Coverage Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees and/or dependents may be able to continue their enrollment in certain health plans such as medical and dental, if such coverage is terminated or changed due to a qualifying event.

Medicare Part D Creditable Coverage

The City of West Palm Beach prescription drug coverage is considered Creditable Coverage under Medicare Part D. If you or your dependents are or will be eligible for Medicare, you may obtain more information by requesting a Medicare Part D Disclosure of Creditable Coverage Notice.

Online Benefit Enrollment

BenTek

Technical Support - Email: support@mybentek.com

Technical Support - Phone: (888) 5-BenTek (523-6835)

Online enrollment with BenTek!

The City of West Palm Beach provides electronic enrollment through BenTek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to make group insurance benefit elections and changes online during the annual open enrollment, new hire orientation and qualifying events module.

To access the Employee Benefits Center during open enrollment:

- Log on to <https://www.mybentek.com/wpb>
- If you forget your username and/or password, click on the link "Forgot Username" or "Forgot Password" and follow the instructions.
- Enter BenTek to review current elections, learn about your benefit options, and make any elections or changes.
- You may also submit and update your life insurance beneficiary designation(s).

You have the option to print out your enrollment confirmation statement containing all your benefit elections for you and your family, including your life insurance beneficiary designations.

Accessible 24 hours a day during the open enrollment process, information about all of your employee benefits election options, including premiums and carrier contact information, is also available to help you make informed decisions. You can also log on to the EBC at any time to review your benefits, access carrier links, update life insurance beneficiaries and report qualifying events.

If any technical questions arise while visiting the EBC, please email BenTek Support at support@mybentek.com or call (888) 5-BenTek (523-6835), Monday through Friday, during regular business hours.

To access your group insurance benefits online, log on to <https://www.mybentek.com/wpb>

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is **inserted here or provided as a supplement** to this booklet which is being distributed to New Hires and Existing Employees during open enrollment. The summary is an important item in understanding your benefit options. A copy of the SBC document is also available as follows:

From: Human Resources/Benefits Department

Address: 401 Clematis Street, 3rd Floor

West Palm Beach, FL 33401

Phone: (561) 494-1000

Through the enrollment software – BenTek: www.mybentek.com/wpb

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 actual group certificate of coverage can be reviewed and obtained by contacting the Human Resources/Benefits Department or at the following web address: www.mybentek.com/wpb.

If you have any questions about the plan offerings or coverage options, please contact the Human Resources/Benefits Department at (561) 494-1000.

Group Insurance Eligibility

The City's group insurance plan year is **July 1, 2015 through June 30, 2016**.

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 the **1st of the month following 30 days of employment**. For example: If you are hired on April 11th, your coverage will be effective on June 1st.

Termination

If you separate employment from the City, medical, dental and vision insurance will continue through the end of the month in which the separation occurred. 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 the spouse/domestic partner. Dependent children may be covered through the end of the calendar year in which the child reaches age 26 for medical, dental and vision. The term "child" includes any of the following:

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

Dependent Eligibility Age Requirements

Eligibility requirements for eligible Over-age Dependents have been eliminated for group medical, dental, and vision insurance. Dependents may be covered by the medical, dental and vision plans through the end of the calendar year in which the child turns age 26.

Medical coverage may continue to the end of the calendar year in which the dependent reaches the age of 30, if the dependent is:

- 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 handicapped.

Disabled Dependents

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

1. The dependent is physically or mentally disabled and incapable of self-sustaining employment; AND
2. The dependent is otherwise eligible for coverage under the group medical plan; AND
3. The dependent has been continuously insured; AND
4. Coverage began prior to the age of 19.

Proof of disability will be required upon request. Please contact the Human Resources/Benefits Department if further clarification is required.

Taxable Dependents

IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to non-qualified dependents; therefore, employees covering adult children under their health 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 the child reaches age 26. **Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, employees will be charged an additional premium on a post-tax basis to continue coverage for such dependents.** Please refer to page 6 for the Over-age Dependent rate. Contact the Human Resources/Benefits Department for further details if you are covering an adult child who will turn 27 any time during the upcoming calendar year or for more information.

Group Insurance Eligibility *(Continued)*

Domestic Partner Coverage

The City offers domestic partner benefits to a person whom the employee shares a mutual residence within the context of a committed relationship and who has registered with the City pursuant to Section 42/48 Code of Ordinances 3838-05, found at <http://wpb.org/clerk/domestic-partnership> and has completed a HR/Affidavit of Domestic Partnership form. Both a Certificate of Domestic Partnership and completed HR/Affidavit of Domestic Partnership must be turned in to the Human Resources/Benefits Department along with supporting documentation required on Affidavit for review and approval to be eligible for domestic partner insurance benefits.

Per IRS rules, an employee may not receive a tax advantage on any portion of premium attributable to a domestic partnership; therefore, imputed income for the value of the applicable domestic partner coverage for the period of coverage, including the value of the coverage for a domestic partner's child(ren), must be reported on the employee's W-2 and taxed accordingly. Imputed income is the dollar value of insurance coverage attributable to covering the domestic partner (and the domestic partner's child(ren)). However, the City of West Palm Beach has established a policy of tax equity for domestic partnership with regards to health insurance benefits pursuant to Section 62-66 Code of Ordinances 4469-13, which states that an employee who insures a domestic partner shall be entitled to a tax reimbursement stipend equal to the gross up amount of income tax imputed to the employee for the value of the health insurance premium paid on behalf of the domestic partner. The effect of that tax reimbursement stipend is to attempt to leave the employee in the same after tax position as an employee who is not subject to taxation on their health insurance premium.

Domestic Partners Who Become Married: Opposite or Same Sex Domestic Partners (IRS Revenue Ruling 2013-17) who become legally married need to notify the Human Resources/Benefits Department during Open Enrollment or within 30 days of marriage.

PLEASE CONTACT THE HUMAN RESOURCES/BENEFITS DEPARTMENT IF YOU ARE COVERING AN OVERAGE DEPENDENT OR A DOMESTIC PARTNER FOR FURTHER DETAILS.

Qualifying Events and IRS Code Section 125

IRS Code Section 125

Premiums for medical, dental, vision insurance, and/or certain Aflac policies and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made **ONLY** during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, if the event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Examples of qualifying events include the following:

- You get married or divorced
- Birth of a child (60 day notification period)
- You gain legal custody or adopt a child
- Your spouse and/or other dependent(s) die(s)
- You, your spouse, or eligible dependent(s) terminate or start employment
- An increase in your work hours causes eligibility
- A decrease in your work hours causes ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)

Please Note the Following:

- *Purchasing or dropping an individual policy for a covered dependent IS NOT a qualifying event and does not permit adding or dropping a dependent from the group health plan outside of Open Enrollment.*
- *Qualifying events allow you to only make changes to your existing coverage, it does not allow you to change your current insurance plan(s).*

IMPORTANT

If you experience a qualifying event, you must contact the Human Resources/Benefits Department within 30 days (30 to 60 days for newborns) of the event to make the appropriate changes to your coverage. Beyond the qualifying event deadline date, the request for change will be denied and you may be responsible both legally and financially for any claim and/or expense incurred as a result of you or a dependent who continued to be enrolled but not longer met the eligibility requirements.

(Furnishing Valid documentation supporting the qualifying event is required)

NEWBORNS: If the qualifying event is a birth of a child, the newborn will be covered for the first 31 days of life even if you fail to enroll the child. The employee contacting the Human Resources/Benefits Department within 30 days of the birth allows for the first month employee contributions of premium to be waived. If the newborn is enrolled after the first 31 days but the employee meets the deadline to enroll by the 60th day after the birth, coverage will be offered at an additional premium (employee contributions back to date of birth).

Medical Insurance Premiums

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

The City offers medical insurance through Cigna to benefit eligible employees. The cost of coverage per month is listed in the premium tables below. For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided.

Medical Insurance – Base OAPIN High Deductible Health Plan (HDHP) Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	\$24.65	\$468.37	\$493.02
Employee + 1 Dependent	\$260.12	\$780.35	\$1,040.46
Employee + Family	\$361.93	\$1,085.79	\$1,447.72
Over-Age Dependent ^{1,2}	\$247.56	\$0.00	\$247.56

1) For the entire 2015-2016 Benefits year, an over-age dependent is defined as: "a dependent who will reach age 27, 28, 29, or 30 during 2015-2016".

2) Additional post tax payroll deduction.

Medical Insurance – Buy-Up OAPIN High Deductible Health Plan (HDHP) Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	\$31.14	\$461.88	\$493.02
Employee + 1 Dependent	\$328.18	\$712.28	\$1,040.46
Employee + Family	\$456.54	\$991.18	\$1,447.72
Over-Age Dependent ^{1,2}	\$247.56	\$0.00	\$247.56

Medical Insurance – Base & Buy-Up OAPIN High Deductible Health Plan (HDHP) – Domestic Partner Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value ¹	\$547.44
Employee + Domestic Partner + Employee Child(ren) Value ¹	\$547.44
Employee + Domestic Partner + Domestic Partner Child(ren) Value ¹	\$954.70

1) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.

Medical Insurance: OAPIN High Deductible Health Plan (HDHP) At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

Network	Open Access Plus
HRA Funding (City Contribution)	In Network
Employee	Please refer to page 9 for Base & Buy-Up HRA Funding Options.
Employee + 1	
Employee + Family	
Plan Year Deductible (PYD)	In Network
Employee	\$1,500
Employee + 1	\$2,250
Employee + Family	\$3,000
Coinsurance	In Network
Member Responsibility	20%
Plan Year Out-of-Pocket Limit	In Network
Employee	\$3,000
Employee + 1	\$4,500
Employee + Family	\$6,000
What Applies to the Out-of-Pocket Limit?	Deductibles and Coinsurance (Includes Rx)
Physician Services	In Network
Primary Care Physician (PCP) thru Employee Health Center	No Charge at Health Center Only
Physician and/or Specialist Office Visit	20% After PYD
Diagnostic Services	In Network
Lab (Blood Work) thru Employee Health Center	No Charge at Health Center Only
Clinical Lab (Blood Work) at Independent Facility	20% After PYD
X-rays thru Employee Health Center	No Charge at Health Center Only
X-rays at Independent Facility	20% After PYD
Advanced Imaging (MRI, PET, CT)	
Hospital Services	In Network
Inpatient and/or Outpatient	20% After PYD
Physician Services at Hospital	
Emergency Room	
Urgent Care Facility	
Mental Health / Alcohol & Substance Abuse	In Network
Inpatient and/or Outpatient	20% After PYD
Prescription Drugs (Rx)	In Network
Generic thru Employee Health Center	No Charge thru Health Center Only
Generic	20% After PYD
Preferred Brand Name	30% After PYD
Non-Preferred Brand Name	40% After PYD
Mail Order Drug (90 Day Supply)	Included

Group Plan Number: 3332277

Health Reimbursement Account

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan or your Health Reimbursement Account, please contact Cigna's Customer Service at (800) 244-6224.

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

The City is providing employees who participate in the **Cigna High Deductible Health Plan** with a Health Reimbursement Account (HRA). The City utilizes Cigna for the administration of the Health Reimbursement Account (HRA). HRA monies are not taxable and funded by the City and can be used for any qualified medical expenses such as **deductibles and coinsurance** for physician services, hospital services, prescription drugs, etc. The HRA monies provide tax-free funds to cover those expenses incurred under the medical plan.

All employees will be defaulted into the **Base** HRA plan. All employees have the option of enrolling in the **Buy-Up** HRA plan.

HRA Funding Allotment for **BASE** High Deductible Health Plan

	Health Reimbursement Account (HRA) Funded by City Upon Employee Enrollment	Optional City Funded HRA Funding Upon Employee's Completion of Health Assessment (HA)*	Employee Responsibility of Deductible for Plan Year	Total Cost of Plan Year Deductible
	(1)	(2)	(3)	(4)
Employee Only	\$1,000 +	\$400 +	\$100 =	\$1,500
Employee + 1 Dependent	\$1,500 +	\$400 + \$200 (Spouse / DP)* +	\$150 =	\$2,250
Employee + Family	\$2,000 +	\$400 + \$400 (Spouse / DP)* +	\$200 =	\$3,000

* If a spouse / domestic partner is covered, they will have to complete a Health Assessment (HA) in order to receive the full HRA amount. Dependent children covered on the medical plan are not required to complete a Health Assessment for the plan year.

HRA Funding Allotment for **BUY-UP** High Deductible Health Plan

	Health Reimbursement Account (HRA) Funded by City Upon Employee Enrollment	Optional City Funded HRA Funding Upon Employee's Completion of Health Assessment (HA)*	Total HRA Funding (Funded by City)	Total Cost of Plan Year Deductible	HRA Funding Bonus
	(1)	(2)	(3)	(4)	(5)
Employee Only	\$1,350 +	\$400 =	\$1,750	-\$1,500 =	\$250
Employee + 1 Dependent	\$2,300 +	\$400 + \$200 (Spouse / DP)* =	\$2,900	-\$2,250 =	\$650
Employee + Family	\$3,200 +	\$400 + \$400 (Spouse / DP)* =	\$4,000	-\$3,000 =	\$1,000

* If a spouse / domestic partner is covered, they will have to complete a Health Assessment (HA) in order to receive the full HRA amount. Dependent children covered on the medical plan are not required to complete a Health Assessment for the plan year.

Optional HRA Funding:

- You have the opportunity to rollover any unused funds year to year, up to a maximum of: Employee Only \$7,500; Employee + 1 Dependent \$11,250; Employee + Family \$15,000
- To receive optional City HRA funding you must complete the following steps:
 - Employee (and or spouse if applicable) must complete lab testing (blood work) with the City's Health Center.
 - Upon Completion of the Lab testing the employee (and or spouse if applicable) must also meet with a Health Center provider. Once results are reviewed please complete Cigna's online Health Assessment (HA) questionnaire.
 - The Health Assessment must be completed between **July 1, 2015 through December 31, 2015**.
- Any unused will funds, up to the funding maximum, will remain in your account when the new HRA plan year begins. **Therefore, as of July 1, 2015 any unused funds from the previous year will be available to use.**

Health Reimbursement Account *(Continued)*

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan or your Health Reimbursement Account, please contact Cigna's Customer Service at (800) 244-6224.

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

HRA IRS Guidelines

HRA's must be funded solely by an employer. The contribution cannot be paid through a voluntary salary reduction agreement on the part of an employee. Employees are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. An HRA may be offered with other health plans, including Flexible Spending Accounts.

What are the benefits of an HRA?

- Contributions made by your employer can be excluded from your gross income.
- Reimbursements may be tax free if you pay qualified medical expenses.
- Any unused amounts in the HRA can be carried forward for reimbursements in later years.

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 you and your dependents who are enrolled in medical plan
- Unused funds accumulate and roll over year to year

Flexible Spending Accounts (FSA)

- **Employee** Funded Accounts
- You must enroll annually
- Funds used for eligible medical, dental, vision & dependent care for you and your qualified dependents
- Unused funds will be forfeited at the end of the plan year (once the filing deadlines have expired).

Please Note: If you voluntarily contribute to a Flexible Spending Account, your HRA pays first, then your FSA. You may voluntarily choose to utilize FSA Funds prior to utilizing HRA Funds. To change your HRA utilization settings please log on to www.mycigna.com or contact the Cigna On Site Representative at (561) 494-1032. Select "Review My Coverage," then click on "Health Reimbursement Account" and choose "Autopay/Change." Please contact the Human Resources/Benefits Department for more information.

Do I still need to keep my receipts?

Yes. During the year, you should keep all receipts and documentation for all eligible expenses for all transactions so that you have them if needed to verify a claim for Cigna or for IRS taxes. If asked to produce documentation, a valid Explanation of Benefits (EOB) and receipt of payment for the services rendered will be sufficient.

How can I find my available HRA balance?

You can check your available balance, activity and account history anytime online at www.cigna.com or you can call (800) 244-6224.

Please Note: The Plan Year Deductibles exceed 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.

At Retirement

Upon age 55+ or 25 years of service **and** retiring from the City, employees can transfer all remaining unused City HRA funds (up to maximum shown on page 9) to an employer sponsor Retirement Health Savings plan (RHS).

**For information on these methods, see Revenue Ruling 2003-43 on page 935 of Internal Revenue Bulletin (IRB) 2003-21 at www.irs.gov/pub/irs-irbs/irb03-21.pdf, Notice 2006-69, 2006-31 I.R.B. 107 available at www.irs.gov/irb/2006-31_IRB/ar10.html, and Notice 2007-2, 2007-2 I.R.B. 254 available at www.irs.gov/irb/2007-2_IRB/ar09.html.*

Other Available Plan Resources

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

Cigna offers to all enrolled members and dependents additional services and discounts through value added programs. **For more details regarding other available plan resources, please refer to your Summary of Benefits and Coverage (SBC).**

Healthy Rewards

Cigna's Healthy Rewards is provided to you automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to www.mycigna.com, click on "Review My Coverage"; then select "Discount Programs - Healthy Rewards" to learn more about these programs or call 1-800-870-3470.

- Weight Management and Nutrition
- Fitness and Mind/Body
- Vision, Hearing and Dental Care
- Tobacco Cessation
- Alternative Medicine
- Wellness and Healthy Products

24 Hour Help Information Hotline (800) CIGNA-24

The Cigna 24-Hour Health Information Line provides you access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do when your child has a fever in the middle of the night? Have you injured yourself and are not sure if you should seek treatment or go see a doctor? There are over 1,000 topics in the Health Information Library that include FREE audio, video and printed information on aging, women's health, nutrition, surgery and specific medical conditions to help you weigh the risks and advantages of treatment options. The call is FREE and is strictly confidential.

The myCigna Mobile App

The myCigna Mobile App gives you an easy way to organize and access your important health information. Anytime. Anywhere. Download it today from the App StoreSM or Google PlayTM. With the myCigna Mobile App you can:

- Find a doctor, dentist or health care facility
- Access maps for instant driving directions
- View ID cards for the entire family
- Review deductibles, account balances and claims
- Compare prescription drug costs
- Speed-dial Cigna Home Delivery PharmacyTM
- Store and organize all important contact info for doctors, hospitals, and pharmacies
- Add health care professionals to contact list right from a claim or directory search
- And, much more!

How to Locate A Provider

To search for a participating provider, contact Customer Service or visit www.cigna.com. You may either log into mycigna.com and search for a participating provider, or click the "Find a Doctor" tab. Then under Choose a Directory, select "If your insurance plan is offered through work or school... Find a doctor or dentist using this directory" box. Under Select a Plan, click "Pick." Select the "Open Access Plus, OA Plus, Choice Fund OA Plus" medical plan option, then click "Choose." Complete the additional search criteria, then "Search."

Dental Insurance: CompBenefits DHMO CS150 Plan

Humana/CompBenefits

Customer Service: (800) 233-4013

www.mycompbenefits.com

The City provides dental insurance through Humana. A brief description of the CompBenefits DHMO CS150 Plan is provided below, and the employee costs are shown on the premium table to the right, with a summary of the plan's schedule of benefits on the following pages. For detailed coverages, exclusions and stipulations please refer to the carrier's benefit summary or contact Humana.

Group ID Numbers			
PMSA	CP 1851	FF & PBA (Grandfathered)	CP 1850
SEIU	CP 1853	COBRA	CP 1849
Unclass / None / Conf	CP 1854	Retiree's	CP 1852

Dental Insurance – CompBenefits DHMO CS150 Plan Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	\$0	\$11.94	\$11.94
Employee + 1 Dependent	\$6.20	\$14.32	\$20.52
Employee + Family	\$17.60	\$12.80	\$30.40

In-Network Benefits

The DHMO plan is an "in-network" only plan that **requires** you to select and receive services from a Primary Dental Provider. In order to receive services, you can select any participating dentist in the network. The network of participating providers who this dental plan utilizes is the "DHMO Network."

The DHMO plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following pages. Please refer to your plan's certificate of coverage for a detailed listing of charges and what is covered.

How to Locate a Provider

To search for a participating provider, contact Customer Service or visit www.compbenefits.com and under the "Providers/Search" tab click on "Find Dental Providers." Under Plan Type Options, choose "DHMO Plans," complete your search criteria, then click "Submit."

Out-of-Network Benefits

This plan does not provide any coverage for services received out of network. If you use an out-of-network dental provider you will pay out of pocket and will not be reimbursed.

Plan Year Deductible

There is no deductible that needs to be met on this plan.

Plan Year Benefit Maximum

This plan is not subject to any benefit maximums.

Please Note the Following:

- Each covered family member may receive up to 2 FREE cleanings per year (must be 6 months apart) covered under the preventative benefit. Members can also receive 2 additional cleanings at the charge of a copay.
- No referrals are necessary for specialty dentists in the network.
- Unlisted covered dental care services may be available at the participating dentist's usual fee less 25%. Not all dentists perform all services.
- Service frequencies and age limitations may apply for some services.

Dental Insurance – CompBenefits DHMO CS150 Plan – Domestic Partner Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value ¹	\$8.58
Employee + Domestic Partner + Employee Child(ren) Value ¹	\$8.58
Employee + Domestic Partner + Domestic Partner Child(ren) Value ¹	\$18.46

¹) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.

Dental Insurance: CompBenefits Advantage Plan AVN4S

Humana/CompBenefits

Customer Service: (800) 233-4013

www.mycompbenefits.com

The City offers dental insurance through Humana. A brief description of the CompBenefits Advantage AVN4S Plan is provided below, and the employee costs are shown on the premium table to the right, with a summary of the plan's schedule of benefits on the following pages. For detailed coverages, exclusions and stipulations please refer to the carrier's benefit summary or contact Humana.

Group ID Numbers			
PMSA	CP 4151	FF & PBA (Grandfathered)	CP 4150
SEIU	CP 4153	COBRA	CP 4149
Unclass / None / Conf	CP 4154	Retiree's	CP 4152

Dental Insurance – CompBenefits Advantage Plan AVN4S Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	\$11.28	\$11.94	\$23.22
Employee + 1 Dependent	\$25.62	\$14.32	\$39.94
Employee + Family	\$46.36	\$12.80	\$59.16

Dental Insurance – CompBenefits Advantage Plan AVN4S Domestic Partner – Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value ¹	\$16.72
Employee + Domestic Partner + Employee Child(ren) Value ¹	\$16.72
Employee + Domestic Partner + Domestic Partner Child(ren) Value ¹	\$35.94

1) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: *If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.*

In-Network Benefits

The Advantage plan is an “in-network” only plan that allows you to receive services from any dental provider without first selecting or coordinating your care through a Primary Dental Provider. The network of participating providers who this plan utilizes is the “**Advantage**” Network.

The Advantage plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following pages. Please refer to your plan's certificate of coverage for a detailed listing of charges and what is covered.

How to Locate a Provider

To search for a participating provider, contact Customer Service or visit www.compbenefits.com and under the “Providers/Search” tab click on “Find Dental Providers.” Under Plan Type options, choose “**AdvantagePlus Plans**”, complete your search criteria, then click “Submit.”

Out-of-Network Benefits

This plan does not provide any coverage for services received out of network. If you use an out-of-network dental provider you will pay out of pocket and will not be reimbursed.

Plan Year Deductible

There is no deductible that needs to be met on this plan.

Plan Year Benefit Maximum

This plan is not subject to any benefit maximums.

Please Note the Following:

- Each covered family member may receive up to 2 FREE cleanings per year (must be 6 months apart) covered under the preventative benefit.
- No referrals are necessary for specialty dentists in the network.
- Unlisted covered dental care services may be available at the participating dentist's usual fee less 20%. Not all dentists perform all services.

Dental Insurance: CompBenefits DHMO & Advantage Plan Side by Side At-A-Glance

Class I Services: Diagnostic & Preventative	Code	CS150	Advantage
Office Visit	9430	\$5 Copay	N/A*
Emergency Care to Relieve Pain (During Regular Hours)	9999	\$20 Copay	N/A
Routine Oral Exam (1 Every 6 Months)	0120	No Charge	No Charge
Routine Cleanings (1 Every 6 Months)	1110/20	No Charge	No Charge
Additional Routine Cleanings	1110/20	\$20 Copay	20% Discount
Bitewing X-rays (4 Films; 1 Every 6 Months)	0274	No Charge	No Charge
Panoramic X-rays (1 Set Every 3 Years)	0330	No Charge	No Charge
Sealants - Per Tooth (Children Under Age 14)	1351	\$10 Copay	No Charge
Fluoride Treatments (Children Under Age 16; Every 6 Months)	1203	No Charge	No Charge
Space Maintainer (Children Under Age 14)	1510/15	\$45 Copay + Lab	No Charge
Class II Services: Basic Restorative	Code	In Network	In Network
Fillings (Amalgam; 3 Surfaces)	2160	No Charge	No Charge
Fillings (Composite; 3 Surfaces, Anterior)	2332	\$50 Copay	No Charge
Fillings (Composite; 3 Surfaces, Posterior)	2393	\$100 Copay	No Charge
Extractions (Erupted Tooth or Exposed Root)	7140	No Charge	No Charge
Root Canal Therapy (Molar)	3330	\$250 Copay**	No Charge
Surgical Removal of Tooth (Erupted/Impacted)	7210/7240	\$40 Copay/\$85 Copay	No Charge
Full Mouth Debridement (Deep Cleaning; 1 Every 5 Years)	4355	\$45 Copay	No Charge
Periodontal Maintenance	4910	\$50 Copay	No Charge
Class III Services: Major Restorative	Code	In Network	In Network
Bridges (Porcelain Fused to High Noble Metal)	6240	\$280 Copay***	\$426 Copay
Crowns (Porcelain Fused to High Noble Metal)	2750	\$280 Copay***	\$466 Copay
Dentures	5110/20	\$300 Copay + Lab	\$642 Copay
Class IV Services: Orthodontia	Code	In Network	In Network
Benefit — Child to age 19	8070/8080	\$1,800	\$2,100
Benefit — Adults and Dependent Children (Age 19 and Over)	8090	\$2,000	\$2,300
Records/Treatment Planning	8070/80/90	\$250 Copay	\$250 Copay
Retention	8680	\$450 Copay	\$450 Copay

* Not a Standalone code on the AVN45 - Dentist should code for the service performed, not the office visit.

** Excluding Final Restoration.

*** Copays for these services do not include the additional cost of precious (High Noble) and semi-precious (Noble) metal. The additional cost of precious metal shall not exceed \$125 per unit and \$75 per unit for semi-precious metal.

Please Note the Following:

- You **must** receive services from facilities and providers in the CompBenefits **DHMO** or **Advantage Network** for benefits to be covered.
- Participants covering young children may be seen by a pediatric dental provider up to the child's 7th birthday. Once the child reaches age 7, a referral with medical documentation will be required prior to being seen by a pediatric dental provider.

The above summary has been provided as a convenient reference. For a full listing of covered services, exclusions and stipulations please see the plan's Schedule of Benefits or contact Humana/CompBenefits Customer Service.

Dental Insurance: CompBenefits Elite Preferred 710 PPO Plan

Humana/CompBenefits

Customer Service: (800) 233-4013

www.mycompbenefits.com

The City offers dental insurance through Humana. A brief description of the Elite Preferred 710 PPO Plan is provided below, and the employee costs are shown on the premium table to the right, with a summary of the plan's schedule of benefits on the following page. For detailed coverages, exclusions and stipulations please refer to the carrier's benefit summary or contact Humana.

Group ID Numbers			
PMSA	CP 4151	FF & PBA (Grandfathered)	CP 4150
SEIU	CP 4153	COBRA	CP 4149
Unclass / None / Conf	CP 4154	Retiree's	CP 4152

Dental Insurance – CompBenefits Elite Preferred 710 PPO Plan Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	\$23.20	\$11.94	\$35.14
Employee + 1 Dependent	\$54.96	\$14.32	\$69.28
Employee + Family	\$108.00	\$12.80	\$120.80

In-Network Benefits

The dental PPO plan option is an "open access" plan that allows you to receive services from any dental provider without first selecting or coordinating your care through a Primary Dental Provider. This plan utilizes "PPO network" providers. To determine if your dentist is in the Network, contact Customer Service or visit www.compbenefits.com and under the "Providers/Search" tab, click on "Find Dental Providers." Under Plan Type Options, choose "PPO plans," complete your search criteria, then click "Submit."

Out-of-Network Benefits

Providers who do not contract with insurance carriers because they do not accept their discounted rates are referred to as "non-participating" or "out of network." Understanding how your insurance company pays for out-of-network services is important because you will usually pay more. Therefore, you have the potential to maximize your benefits when services are received by in-network providers.

The insurance company processes charges based on the negotiated Maximum Allowable Fee (MAF) amount. When utilizing a non-participating dentist, you will be responsible for any extra amount charged by the dentist over the negotiated maximum and customary charge of the dentist. Since there is no contract in place between the insurance company and out-of-network provider, the provider may charge an amount higher than the MAF. The difference between the MAF amount and the provider's higher charge is called "balance billing." **Balance billing is in addition to your deductible and coinsurance responsibility.**

Plan Year Deductible

The dental PPO plan benefits begin once each covered member satisfies a \$50 deductible (waived for Class I services). The deductible is applied collectively for either in or out-of-network services or any combination of both. Once any 3 covered members in a family each satisfies the \$50 deductible, the deductible will then be considered met for all covered members in that family.

Plan Year Benefit Maximum

The maximum benefit (coinsurance) the dental PPO plan will pay for each covered member is \$1,000 for in-network or out-of-network services or a combination of both. All services, including diagnostic and preventive, count toward your Plan Year Benefit Maximum.

Please Note the Following:

- Each covered family member may receive up to 2 FREE cleanings per plan year covered under the preventative benefit.
- Service frequencies and age limitations may apply for some services.

Dental Insurance – CompBenefits Elite Preferred 710 PPO Plan – Domestic Partner Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value ¹	\$34.14
Employee + Domestic Partner + Employee Child(ren) Value ¹	\$34.14
Employee + Domestic Partner + Domestic Partner Child(ren) Value ¹	\$85.66

¹) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.

Dental Insurance: CompBenefits Elite Preferred 710 PPO Plan At-A-Glance

Network	PPO	
Plan Year Deductible (PYD)	In and Out of Network Combined	
Per Member	\$50	
Per Family	\$150	
Waived for Class I Services?	Yes	
Plan Year Benefit Maximum	In and Out of Network Combined	
Per Member	\$1,000	
Class I Services: Diagnostic & Preventative	In Network	Out of Network*
Oral Exam (1 Every 6 Months)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived <i>(Subject to Balance Billing)</i>
Prophylaxis/Cleanings (1 Every 6 Months)		
X-rays (Limitations May Apply)		
Fluoride Treatments (1 Per Year; Children Under Age 16)		
Sealants (1 Every 3 Years; Children Under Age 16)		
Space Maintainers (Children Under Age 16)		
Class II Services: Basic Restorative	In Network	Out of Network*
Fillings (Amalgams, Synthetic or Composite)	Plan Pays: 80% After PYD	Plan Pays: 80% After PYD <i>(Subject to Balance Billing)</i>
Emergency Palliative Treatment		
Tooth Extraction		
Endodontics (Root Canals)		
Periodontics (Includes the Treatment of Gum Diseases)		
Class III Services: Major Restorative	In Network	Out of Network*
Major Restorative (Crowns, Inlays, Onlays)	Plan Pays: 50% After PYD	Plan Pays: 50% After PYD <i>(Subject to Balance Billing)</i>
Prosthetics (Bridges & Dentures)		
Bridge & Denture Repair		

*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 Out-of-Network Benefits section on the previous page.

A predetermination of benefits is required for non emergency treatment expected to cost more than \$200. Please ask your dentist to file the predetermination with Humana prior to having treatment started.

The above summary has been provided as a convenient reference. For a full listing of covered services, exclusions and stipulations please see the plan's Schedule of Benefits or contact Humana/CompBenefits Customer Service.

Vision Insurance: Humana Vision Care Plan

Humana/CompBenefits

Customer Service: (866) 537-0229

www.compbenefits.com

The City provides vision insurance through Humana. A brief description of the Humana Vision Care Plan is provided below, and the employee costs are shown on the premium table to the right, with a summary of the plan's schedule of benefits on the following page. For detailed coverages, exclusions and stipulations please refer to the carrier's benefit summary or contact Humana.

In-Network Benefits

The vision plan offers you and your covered dependents coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered members can select any optometrist or ophthalmologists that participates in the **Humana Vision Care 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 your appointment.

Out-of-Network Benefits

Covered members may also choose to receive services from vision providers who do not participate in the vision network. If so, the cost of the services received would be paid to that provider at the time of the scheduled appointment. Humana will then reimburse the covered members based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered. Contact Humana's Customer Service for an out-of-network reimbursement schedule.

How to Locate a Provider

To search for a participating provider, contact Customer Service or go to www.compbenefits.com and under the "Providers/Search" tab click on "Find Vision Care Providers." Choose "**Vision Care Plan**" and then fill out the search criteria and click "Search."

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 per calendar year.

Please Note the Following:

- Members receive additional fixed copayments on lens options including anti-reflective and scratch-resistant coatings. Contact Humana for more information.
- Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam, and is available through the VCP network provider who sold the initial pair of eyeglasses.
- After copay, standard polycarbonate available at no charge for dependents under age 19.

Vision Insurance – Humana/CompBenefits Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	\$0.00	\$4.48	\$4.48
Employee + 1 Dependent	\$0.00	\$12.80	\$12.80
Employee + Family	\$0.00	\$12.80	\$12.80

Vision Insurance – Humana/CompBenefits – Domestic Partner Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value ¹	\$4.48
Employee + Domestic Partner + Employee Child(ren) Value ¹	\$4.48
Employee + Domestic Partner + Domestic Partner Child(ren) Value ¹	\$8.32

1) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.

Vision Insurance: Humana Vision Care Plan At-A-Glance

Services	In Network	Out of Network
Eye Exam	\$10 Copay	Up to \$35 Reimbursement
Frequency of Services	In Network	Out of Network
Examination	12 Months	12 Months
Lenses	12 Months	12 Months
Frames	24 Months	24 Months
Contact Lenses	12 Months	12 Months
Lenses	In Network	Out of Network
Single	Paid in Full	Up to \$25 Reimbursement
Bifocal		Up to \$40 Reimbursement
Trifocal		Up to \$60 Reimbursement
Contact Lenses	In Network	Out of Network
Non-Elective (Medically Necessary)	Paid in Full ¹	Up to \$210 Reimbursement
Elective (Fitting, Follow-up & Lenses)	Up to \$105 Allowance ²	Up to \$105 Reimbursement
Frames	In Network	Out of Network
Maximum Allowance	\$40 Wholesale Allowance	\$40 Retail Price Reimbursement
Lasik	In Network	Out of Network
Discount Programs ³	Contact Humana's Customer Service For More Information	Discount Programs Not Available Out of Network

Group Plan Number: VS3150

Please Note:

1. Medically necessary (prior authorization required) is defined as 1) following cataract surgery w/o intraocular lens 2) correction of extreme visual acuity problems not correctable with glasses 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.
2. This allowance is paid with the same frequency as lenses, in place of all other benefits. The allowance applies to materials, evaluation and fitting. Members also receive 15% discount on in-network professional services, available for 12 months after the covered eye exam.
3. Plan members must first contact Humana / CompBenefits for a list of providers who participate in the Vision Care Plan network.

Flexible Spending Accounts

WageWorks (Formerly through FlexOne/Aflac)
 Customer Service: (800) 950-0105
 Mon. – Fri. from 8:00am – 7:00pm CST
www.takecarewageworks.com
www.fsaworksforme.com/takecare

Claims Mail: Aflac Benefit Services
 1932 Wynnton Rd,
 Columbus, GA 31999
 Claims Fax: (877) 353-9256

The City of West Palm Beach offers Flexible Spending Accounts (FSA) administered by WageWorks.

Debit Card

Use the Take Care® Card

Use your take care® card instead of cash or credit at health care providers and pharmacies for eligible services, goods and prescriptions. Typical expenses include co-pays for doctor visits and prescriptions, dental and orthodontia expenses, vision care, prescribed over-the-counter (OTC) drugs and medication and non-drug OTC items and devices.

If you have predictable medical expenses for yourself or your family, such as deductibles and copays, or any work-related day care expenses, FSAs may be right for you. FSAs allow you to set aside money for reimbursement of medical and day care expenses you regularly pay. **The amount you set aside is not taxed and is automatically deducted from your paycheck and deposited into the FSA.** During the year, you have access to this account for reimbursement of qualified expenses that are not covered by insurance. An FSA not only results in a substantial tax savings, it also increases your spending power. There are two types of FSAs:

Health Care Reimbursement Account	Dependent Care Reimbursement Account
<p>This account allows you to set aside up to an annual maximum of \$2,550. This money will not be taxable income to you and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs for you or your qualified dependents. Employees can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).</p> <p>Examples of common expenses that qualify for reimbursement are listed below.</p> <p>*NOTE: The entire Health Care FSA election is available to you on the first day coverage is effective.</p>	<p>This account allows you to set aside up to an annual maximum of \$5,000 if you are single or married and file a joint tax return (\$2,500 if you are married and file a separate tax return) for work-related day care expenses. Qualified expenses include adult and child day care centers, preschool, and before/after school care for eligible children and adults.</p> <p>Please note that if your family's annual income is over \$20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your dependent must be:</p> <ul style="list-style-type: none"> • a child under the age of 13, or • a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household. <p>*NOTE: Unlike the Health Care FSA, you will only be reimbursed up to the amount that has been deducted from your paycheck for Dependent Care expenses.</p>

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

- Ambulance service
- Chiropractic care
- Dental fees/Orthodontic fees
- Diagnostic tests/Health screenings
- Doctor fees
- Drug addiction/Alcoholism treatment
- Experimental medical treatment
- Eyeglasses/Contact lenses (corrective)
- Hearing aids and exams
- Injections & vaccinations
- Lasik surgery
- Mental healthcare
- Nursing services
- Optometrist fees
- Physician office visits
- Prescription drugs
- Medically Necessary Sunscreen
- Wheelchairs

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

- Any unused funds after a plan year ends and all claims have been filed cannot be returned to you or carried forward to the next plan year.
- You have a 2.5 month grace period at the end of the plan year to file for claim reimbursement on eligible expenses incurred during the period of coverage within the plan year.
- Must be renewed annually to continue benefit for following year.
- You can enroll in either or both FSAs during open enrollment period, a qualifying event or new hire eligibility only.
- You cannot transfer money between FSAs.
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You cannot be reimbursed for a service which you have not received.
- You cannot receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- Domestic partners are not eligible as federal law does not recognize them as a qualified dependent.

Here's How It Works

An employee earning \$30,000 elects to place \$1,000 into their FSA Health Care Savings Account, with payroll deductions being \$41.67 based on a 24 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of \$227.

	With the Plan	Without the Plan
Salary	\$30,000	\$30,000
FSA Contribution	- \$1,000	- \$0
Taxable pay	\$29,000	\$30,000
Estimated Tax 22.65% = 15% + 7.65 FICA	- \$6,568	- \$6,795
After Tax Expenses	- \$0	- \$1,000
Spendable Income	\$22,432	\$22,205
Tax Savings	\$227	

NOTE: Be conservative when estimating your medical and/or dependent care expenses. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and all claims have been filed cannot be returned to you or carried forward to the next plan year. This is known as the "USE IT OR LOSE IT" rule.

Filing a Claim

To file a claim, you must submit your completed claim form and include a copy of the receipt as proof of the expense. Once completed, you may submit your claim either by mail or fax. The IRS requires FSA participants to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

Basic Life and AD&D Insurance

The Hartford

Customer Service: (888) 563-1124

Group Plan Number: 6770058

www.thehartfordatwork.com

Basic Term Life

The City provides Basic Term Life Insurance through The Hartford. Your benefit amount is determined by your eligibility classification as described below. Your enrollment is automatic but you are required to designate a beneficiary. Beneficiary designations can be made online at www.mybentek.com/wpb. A beneficiary confirmation statement can also be printed and retained for your records.

Eligibility Classifications		Benefit Classifications
Active Full-time Employees of Management Class 1.	Class 1	1 times annual earnings plus \$100,000, rounded to the next higher multiple of \$1,000, to a maximum of \$250,000.
Active Full-time Employees of Management Class 2 other than members of Professional Managers Supervisors Association (PMSA).	Class 2	1 times annual earnings plus \$50,000, rounded to the next higher multiple of \$1,000, to a maximum of \$250,000.
Active Full-time Employees of Management Class 2 who are members of the PMSA.	Class 3	1 times annual earnings plus \$75,000, rounded to the next higher multiple of \$1,000, to a maximum of \$250,000.
Active Full-time Employees or Elected Officials other than Members of the PMSA, Firefighters and Police Department employees.	Class 4	1 times annual earnings, rounded to the next higher multiple of \$1,000, to a maximum of \$100,000.
Active Full-time Employees who are members of the PMSA who are not in Management Classes 1 or 2, other than Firefighters and Police Department employees.	Class 5	1 times annual earnings plus \$25,000, rounded to the next higher multiple of \$1,000, to a maximum of \$100,000.
Active Full-time Employees of the Police Department who are not in Management Classes 1 or 2.	Class 6	1 times annual earnings, rounded to the next higher multiple of \$1,000, to a maximum of \$100,000.
Active Full-time Employees of the Fire Department who are not in Management Classes 1 or 2.	Class 7	1 times annual earnings, rounded to the next higher multiple of \$1,000, to a maximum of \$100,000.
Retired Employees who retired prior to October 1, 1998 other than employees of the Police and Fire Department.	Class 8	Flat \$7,500.
Retired Employees who retired on or after October 1, 1998 other than employees of the Police and Fire Department.	Class 9	Flat \$10,000.
Retired Employees of the Police Department.	Class 10	Flat \$25,000.
Retired Employees of the Fire Department retired prior to February 1, 2010.	Class 11	Flat \$25,000.
Retired Employees of the Fire Department retired on or after February 1, 2010.	Class 12	Flat \$10,000.

Accidental Death & Dismemberment

For Classes 1 - 7, the City also provides Accidental Death & Dismemberment (AD&D) insurance which pays in addition to, and in an amount equal to, the Basic Term Life Insurance benefit when death occurs as a result of an accident. A partial AD&D benefit may also be payable based on the schedule of benefits. For detailed coverages, exclusions, and stipulations contact The Hartford Customer Service.

Please Note: For Classes 1-7, the Basic Life / AD&D benefit amount reduces starting at age 70. For details regarding all the plan's coverages, exclusions, and stipulations, contact Customer Service or visit The Hartford online at www.thehartfordatwork.com.

**Always remember to keep your beneficiary forms updated.
You may update your beneficiary information at anytime by logging onto
BenTek at www.mybentek.com/wpb**

Supplemental Employee & Dependent Life Insurance

The Hartford
 Customer Service: (888) 563-1124
 www.thehartfordatwork.com

Supplemental Employee Life

The City offers Supplemental Employee Life Insurance through The Hartford. Enrollment is voluntary and 100% employee paid. A summary of the plan's benefit provisions is provided below followed by a premium calculation. Beneficiary designations can be made online at www.mybentek.com/wpb. A beneficiary confirmation statement can also be printed and retained for your records.

Supplemental Employee Life Plan Summary	
Eligibility	All Active Full-time Employees.
Benefit Options	1,2 or 3 times your basic annual earnings to a maximum of \$300,000.
Cost to You	This benefit is 100% employee paid.
Guaranteed Issue	\$250,000 for all first-time eligible employees. Employees who do not enroll when first eligible and later want to add this coverage, or employees who want to increase their current election must submit medical evidence to Hartford Life. Coverage will not be effective unless, and until, Hartford approves your application.
Portability	You can take this coverage with you if you terminate employment prior to normal retirement age. Rates will be similar but not identical.
Age Reduction	Your benefit reduces starting at age 70.

Supplemental Employee Life Monthly Premium Calculation

$$\frac{\text{Elected Benefit Amount}}{\$1,000} = \text{_____} \times \frac{\$0.35}{\text{Monthly Rate per } \$1,000 \text{ of Elected Benefit}} = \text{Your Monthly Cost}$$

Supplemental Dependent Life

The City offers Supplemental Dependent Life Insurance through The Hartford. Enrollment is voluntary and 100% employee paid. A summary of the plan's benefit provisions is provided below followed by a premium calculation. Beneficiary designations can be made online at www.mybentek.com/wpb. A beneficiary confirmation statement can also be printed and retained for your records. **Please note: Employees must participate in the Supplemental Life insurance plan for spouses/dependent child(ren) to participate.**

Supplemental Dependent Life Plan Summary	
Benefit Options	Spouse: Flat \$10,000. Child(ren): Flat \$5,000.
Dependent Spouse	Dependent elections cannot exceed 50% of the employee's inforce life benefit. You may not elect coverage for your spouse if your spouse is covered as an employee under this policy. If both you and your spouse are employees of the City, only one of you may elect coverage for your child(ren).
Dependent Child(ren)	Children from live birth to age 21 are covered, and may remain in the plan to age 25 if a full-time student.
Cost to You	This benefit is 100% employee paid.
Spouse Guaranteed Issue	\$10,000 is the guaranteed issue amount for spouses who are newly eligible for coverage. Employees who have previously declined spouse coverage must submit medical evidence for their spouses to Hartford Life. Coverage will not be effective unless, and until, Hartford Life approves your application.
Child(ren) Guaranteed Issue	All amounts are guaranteed issue, even if enrolling late.
Age Reduction	None.

Supplemental Dependent Spouse Monthly Premium Calculation

$$\frac{\$10,000}{\$1,000} = 10 \times \frac{\$0.35}{\text{Monthly Rate per } \$1,000 \text{ of Elected Benefit}} = \text{Your Monthly Cost } \$3.50$$

Long Term Disability Insurance

The Hartford

Customer Service: (888) 563-1124

www.thehartfordatwork.com

The City provides Long Term Disability (LTD) insurance through The Hartford for all general employees enrolled in the Defined Contribution Retirement Plan. LTD insurance is “income replacement” insurance that pays you a percentage of your monthly earnings if you are unable to work due to illness or a non-work related injury. The City pays for this benefit 100% and your enrollment is automatic. A summary of the plan’s benefit provisions is provided below. For details regarding all the plan’s coverages, exclusions, and stipulations, contact Customer Service or go to www.thehartfordatwork.com.

Long Term Disability Plan Summary	
Definition of Disability	Disability means that you cannot perform one or more of the essential duties of your occupation due to a non-work related injury, illness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are 80% or less than your pre-disability earnings. Once you have been disabled for 36 months following the elimination period, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are 60% less than your pre-disability earnings.
Elimination Period	Benefits begin after 90 calendar days.
Benefit Percent	The plan replaces up to 60% of basic monthly earnings.
Monthly Benefit Minimum / Maximum	\$100 / \$5,000
Benefit Duration	If under age 63 when disabled, benefit may be payable up to your Normal Social Security retirement age. If you are 63 or older, benefits may be payable beyond normal retirement age. Consult your certificate for full description.
Pre-existing Condition	Any condition for which you sought medical attention or took medication in the 180 days prior to your coverage becoming effective will not be covered unless the date of the disability follows 365 days of continuous coverage under this plan.
Mental & Nervous / Substance Abuse	24 month limit unless confined to a facility.
Cost to You	None. The City pays for this benefit.

Employee Assistance Program

Aetna Resources for Living
Customer Service: AETNA-EAP (888 238-6232)
www.mylifevalues.com
24 Hour Crisis Line: (800) 272-7252

Username: CWPB
Password: CWPB

The City provides, at no cost to you, a comprehensive Employee Assistance Program (EAP). The EAP program is available to you and each member of your family through Aetna Resources for Living. Aetna offers access to licensed mental health professionals through a confidential program that is protected by state and federal laws. The EAP program is available to help you gain a better understanding of problems that affect you, locate the best professional help for your particular problem, and decide upon a plan of action. All EAP counselors are professionally trained and are certified and licensed in their fields. Master-level counselors are available 24 hours a day, 7 days a week.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employees and their family members free and convenient access to a range of confidential and professional services to help them address a variety of problems that can negatively affect their well-being. Coverage includes 6 face-to-face sessions per issue (per year), phone crisis intervention and referrals to outside resources when necessary. EAP offers counseling services on issues such as:

Emotional Well-Being

- Stress / Depression
- Grief and Loss
- Anger Management

Family Matters

- Marital issues
- Parenting problems
- Domestic violence

Work Issues

- Co-worker Relationships
- Job Burnout
- Work-Related Stress
- Performance Concerns

Addiction and Recovery

- Alcohol and drugs
- Gambling
- Eating Disorders

Legal and Financial Services

- Free 30 minute legal phone or in person consultation
- Free 30 minute financial phone consultation with a financial counselor
- 25% discount when retaining attorney or using network CPA for personal income tax preparation
- Online Will and other sample legal forms
- Online ID Theft & Fraud Resolution Program
- Online access to legal and financial articles

Online Work/Life Services

- Health and Wellness
- Finances and saving money
- Child and elder care provider search features
- Adoption
- Access to savings and rewards programs
- Pet resources and information

Are your services confidential?

Yes. Receipt of EAP Services is completely confidential. If, however, participation in the EAP is a 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 will not, however, receive specific information regarding the referred employee's case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Supplemental Insurance

Aflac

Agent: Linda Carcich

Phone: (561) 784-5256

www.aflac.com

aflac@wpb.org (Lotus Note)

Aflac offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction. Aflac pays money directly to you, regardless of what other insurance plans you may have. Available Aflac plans include:

- Cancer Classic Plan
- Critical Care Plan (Specified Health Event)
- Personal Disability Income Protector
- Accident Indemnity Advantage
- Personal Sickness Indemnity Plan (Level 3)
- Group Accident Plan
- Group Critical Illness Plan

To learn more about these Aflac plans and/or schedule a personal appointment, contact the City's Aflac Agent, Linda Carcich, at (561) 784-5256.

Preferred Legal Plan

Preferred Legal Plan

Customer Service: (888) 577-3476

www.preferredlegal.com

info@preferredlegal.com

City employees have the opportunity to enroll in a voluntary pre-paid legal program through Preferred Legal Plan. By enrolling in this plan, a participant will have direct access to attorneys who will provide legal assistance 24 hours a day / 7 days a week for a variety of situations such as those examples provided in the box below. Additional services may also be provided at discounted rates.

The cost to the employee to participate in this legal plan is \$9.95 per month. This cost is the same for all employees regardless of the number of eligible dependents enrolled in the plan. All premiums will be payroll deducted on a post-tax basis for your convenience.

Preferred Legal Plan service examples:

- Divorce
- Domestic Violence
- Civil Litigation
- Child Custody and Support
- Identity Theft Issues
- Personal Injury
- Bankruptcy
- Criminal Defense
- Traffic Tickets
- Probate
- Immigration
- Wills (Member and Spouse)
- Real Estate
- Credit Report Issues
- Contract Review
- Loan Modifications
- Foreclosure Defense



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