Indian River County Survey on Employee Health Clinics 2020	Responding Agency: City of Cocoa
Contact: Sheila O'Sullivan - 772-226-1377 sosullivan@ircgov.com	**Contact: Tammy Gemmati (321) 433-8665**
Purpose: We are evaluating the different types of employee clinics that various agencies have implemented to evaluate whether implementing a clinic would be beneficial and cost effective.	**Please provide responses below and provide any details and comments that may assist us in evaluating clinic options.**
Your Health Plan Participant Count:	
HISTORY	
Are you self-insured for your health insurance?	Yes
Please provide the employer's monthly contribution towards the various health plan options.	Employee Only $776.28; Employee + 1 $1187.92, Employee + Family $1584.04
Please provide the employee's monthly contribution toward the various health plan options.	Employee Only $0; Employee + 1 $334.646, Employee + Family $656.72
What motivated your agency's decision to pursue a clinic? What were the main drivers?	To contain and maintain the City's health plan costs.
Please list the goals you were hoping to accomplish when implementing a clinic. Employee benefit enhancement? Cost savings? Wellness program? Access to care?	Enhance benefits for employees to get them easily accessible primary health care while help contain the City's health plan costs.
How did you determine your organization was ready to implement a clinic?	The City funded the first year and contruction costs from return on premiums from the previous partially self-funded health plan.
IMPLEMENTATION PROCESS	
How long did it take from the decision to implement to go live?	6-9 months due with RFP for administrator selection and construction of buildout.
Describe the implementation process.	Completed an employee survey to gauge employee interest and they were very interested. Then we put together a group to tour different clinics around our area to see different employee clinics and model types. Our benefit broker helped write the RFP to develop the scope and then evaluated all bids when they came in. We had a selection committee made up of different employee groups to help select the vendor. While the vendor was being selected our benefit broker assisted with reviewing possible city facilities to put the health center in.
What resources did you need? Did you use an outside consultant to assist you?	See above question response.
What were the start up costs?	Buildout and getting facility ready was about $140,000
Which department oversees the clinic and how many staff are allocated in support of employee benefits and the employee clinic?	We have a third party administrator that manages the clinic staff and the Human Resources division oversees the project of the health center. Day-to-day there are not a lot of issues but we have regular meetings scheduled both between Cocoa and the administrator and then separately regular meetings with the cities that we share the clinics with to handle any policy items as a whole.
Describe your communication plan to your members?	We have ongoing communications with flyers and sometimes do postcard mailers so spouses are in the loop.
What challenges did you face and what would you do differently? Describe lessons learned related to implementation?	When we opened the clinic originally we included both group plan retirees and medicare retirees to utilize the clinic, which add to the monthly administration fees since we pay per member per month. Now we have a low utilization on some of the medicare retirees and it is regretted to offer the benefit to them since they are not on our group plan. In hindsight we should have probably just offered the clinic to retirees under 65.
CLINIC MODEL	
When was the clinic implemented?	September 2014 for Cocoa, then entered into Interlocal Agreement with 3 other cities in 2017.
Describe your clinic model. Number of clinic locations, number and type of clinic staff, days and hours of operations, and services provided.	**We have 2 clinic locations. Our Cocoa clinic is open Monday (7:30am-11:30am & 1:00pm-5:00pm), Tuesday (8:00am-12:00pm), Wednesday (8:00am-12:00pm & 1:30pm-5:30pm), Thursday (8:00am-12:00pm), & Friday (7:30am-4:30pm). Our Satellite Beach clinic is open Monday (1:00pm-5:00pm), Tuesday (1:00pm-5:00pm), Wednesday (8:00am-12:00pm), & Thursday (8:00am-12:00pm).**
Who is/are your vendor partner(s)?	CareATC
Who is eligible to visit the clinic and what is the number of eligibles?	Any current employee, spouse, children (over the age of 2), retiree, retiree spouse as long as they are on the City insurance or have waived the stipend they are eligible to receive if they waive City insruance coverage
What is the member cost for a clinic visit?	$0
How is the clinic funded and what are the annual costs?	The clinic is funded by the City at a cost of approximately $500,000 per fiscal year. With the current interlocal agreement, the operating and staff costs are split based on employee headcount and all of the labs and pharmacy are passed through directly to our city for billing.
How are the clinic expenses verified and paid?	Our clinic provider sends an invoice for the total monthly cost every month with a copy of all invoices of products purchased for the month & the salaries of the clinic staff. The documents are reviewed by HR staff & paid if no discrepancies are found. Everything is a "pass through" to the City.

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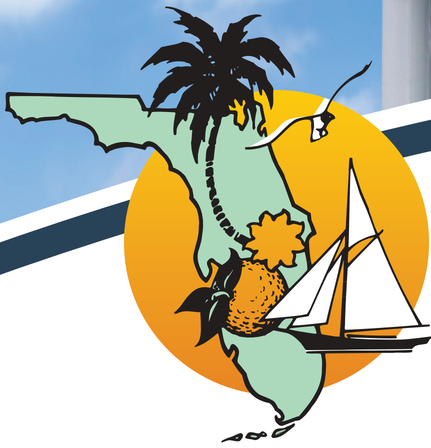
Describe any member incentives or well being strategies associated with the clinic.	Employees & their dependants can visit the clinic at no cost to them for the visit and prescriptions as long as they are either enrolled in the City insurance or have waived insurance but do not collect the monthly stipend associated with waiving insurance. Since opening in 2014, we have offered a day off benefit for those that have their personal health assessment and follow-up visit with the doctor. We also allow employees to go on-duty up to 6 visits a year.
Please describe any innovations or programs running in the clinic that are working well.	We share all of our wellness programs with clinic staff and are able to have a good partnership with the administration.
Please indicate if you have any plans to expand or reduce clinic services in the future.	The operating hours may need to be expanded in the future due to high utilization.
OUTCOMES	
How many of your members are participating in the clinic? Please express as both as a number and percent of total eligibles.	For 2019: 79% Eligible Employees/Retirees and 67% total overall utilization (including dependents and spouses). On Average total number of eligible employees/retirees was 552 and 794 eligible members.
Please describe any metrics you have established to determine clinic outcomes.	Return on investment is reviewed by the benefit broker on a continuous basis.
What reporting do you receive to demonstrate outcomes?	We receive monthly utilization reports from our clinic provider
Please describe success/outcomes that are noteworthy.	Choosing the right provider is key to the success of the clinic. The provider we have is extremly compassionate and truly cares about our employees. I often joke that our employees would jump in front of a moving bus for her. You want someone that will give invest in your employees for their wellness.
Describe employee satisfaction with the clinic. Have you conducted employee surveys related to the clinic, if so please summarize overall employee sentiments related to the clinic.	From our May surverys sent to people who used the clinic it received a score of 94/100. We believe selecting the proper provider is a direct correllation to the utilization and overall satisfaction. We currently have one physician and two nurse practicioners.
Describe how the clinic has met the initial clinic goals stated above. How have you quanitified success as it relates to your upfront goals.	The initial ROI goal was to help get the return on the buildout costs and reduce
Is there anything you would change or do differently if you had it to do it over again?	
Please share any additional information that you believe would be helpful to us as we evaluate the possibility of pursing an employee clinic.	Reviewing the ROI is important but at the end of the day having an employee health clinic is a great benefit and adds value to the organization. It is a great recruitment tool as well.
Medication	
Does the clinic provide medications through the clinic? If so, what are the member copays? If you offer medications with no copays, how was the list of “free” medications determined?	Medication is offered & it is at no cost to the employee.
How did you evaluate which medications to offer through the clinic? What was the main reason you offer medications through the clinic?	Based on common drugs being prescribed under the medical plan, plus any the physician recommended adding.
Is the cost of medications to the employer’s plan, less than the cost through the traditional pharmacy benefit? What data was used to make this determination?	Typically there is a savings but some medications are close to the plan cost. We see it as a convenience to the employees so will do those medications if it will encourage healthy behavior and utilization.
What is the annual cost to the employer’s plan of offering the medications through the clinic?	Based on our benefit broker's recommendation using pharmacy reports from medical plan.
Do you medications expire and have to be disposed of without being dispensed to members?	Medications are administered by CareATC and their pharmacy doctor at corporate. We recently rolled out a mail order pharmacy option as well and that has reduced medications in the clinic being dispensed.



COCOA

FLORIDA

Employee Benefit Highlights

2020 - 2021

SERVING OUR COMMUNITY WITH P.R.I.D.E!

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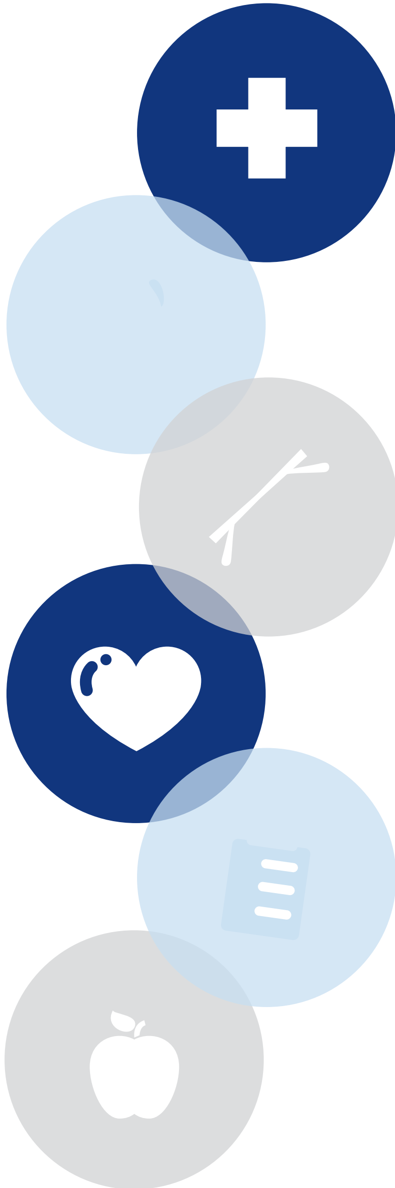

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This booklet is merely a summary of benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City reserves the right to amend, modify or terminate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

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Contact Information

Benefit	Provider	Contact
Human Resources Division		Phone: (321) 433-8440 Email: humanresources@cocoafl.org
Claims, Billing & Benefit Assistance		Phone: (800) 244-3696 Email: cocoa@gehringgroup.com
Online Benefit Enrollment	Bentek Support	(888) 5-Bentek (523-6835) www.mybentek.com/cityofcocoa
Medical Insurance	Cigna *Group# 3339026*	Customer Service: (800) 244-6224 www.mycigna.com
Prescription Drug Coverage & Mail-Order Program	Cigna Home Delivery	Customer Service: (800) 285-4812 www.mycigna.com
Dental Insurance	Cigna *Group# 3339026*	Customer Service: (800) 244-6224 www.mycigna.com
Vision Insurance	EyeMed *Group# 1018022*	Customer Service: (866) 939-3633 www.eyemed.com
Employee Health Center	CareATC	Customer Service: (800) 993-8244 www.careatc.com
FSA Administrator	TASC	Customer Service: (800) 422-4661 www.tasconline.com
Basic Life and AD&D Insurance	Cigna *Life Policy# FLX964922* *AD&D# OK966532*	Customer Service: (800) 732-1603 www.mycigna.com
Voluntary Life Insurance	Cigna *Policy# FLX964922*	Customer Service: (800) 732-1603 www.mycigna.com
Voluntary Short Term Disability Insurance	Cigna *Policy# VDT961221*	Customer Service: (800) 732-1603 www.mycigna.com
Long Term Disability Insurance	Cigna *Policy# LK963434*	Customer Service: (800) 732-1603 www.mycigna.com
Employee Assistance Program	Cigna Behavioral Health	Customer Service: (877) 622-4327 www.mycigna.com
Voluntary Supplemental Insurance	Aflac	Customer Service: (800) 433-3036 www.aflacgroupinsurance.com
Voluntary Legal & Identity Protection Plans	U.S. Legal Services	Agent: Dixie Kuehn Phone: (321) 403-0156 | Email: dixiekuehn@cfl.rr.com
Voluntary 457 Retirement Plan	Nationwide Retirement Solutions *Policy# 0041011001*	Customer Service: (877) 677-3678 www.nrsforu.com
	ICMA Retirement Corporation *Policy# 10-7736*	Customer Service: (800) 669-7400 www.icmarc.org

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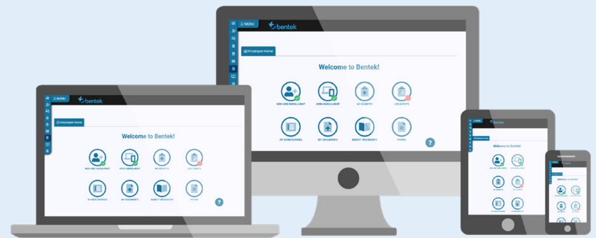
Introduction

The City of Cocoa 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 Cocoa Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact the Human Resources Division for further information.

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 **www.mybentek.com/cityofcocoa**
- ✓ 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 Employee Benefits Center online, log on to:
www.mybentek.com/cityofcocoa

Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*

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Group Insurance Eligibility

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

Please note: Deductible and annual maximums are January 1 to December 31.

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 60 days of employment. For example, if an employee is hired on April 11, then the effective date of coverage will be July 1.

Separation of Employment

If employee separates employment from the City, insurance will continue through the end of month in which separation occurred. 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 spouse. The term "child" includes any of the following:

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

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.

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

Dependent Age Requirements *(Continued)*

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

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

Disabled Dependents

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

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

Proof of disability will be required upon request. Please contact the Human Resources Division if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under employee's 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. The imputed income value per pay period for coverage an overage dependent under the City's medical plan for the period of October 1, 2020 – September 30, 2021 is as follows:

Imputed Income Value

24 Bi-Weekly Deductions - Per Pay Period Cost

Plan	Income Value
Cigna Core Plan	$250.30

***Note:** There is no imputed income if an adult dependent child is eligible to be claimed as a dependent for Federal income tax purposes on the employee's tax return. Overage Dependent Affidavit must be completed and turned into the Human Resources Division. This form can be found in Bentek. Contact the Human Resources Division 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.*

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Group Insurance Eligibility *(Continued)*

Please remember the following: In order to enroll or cover dependent(s) on the City's medical plan, the employee is required to provide documentation verifying the eligibility of such dependents to the Human Resources Division.

Dependent Relationship	Documentation Required
Spouse	• *Official Marriage Certificate **AND*** • *SSN for ACA purposes (Affordable Care Act)*
Child(ren) Under Age 26	• *State issued birth certificate(s) **OR** legal guardianship court documents, listing the employee or spouse as parent/legal guardian **AND*** • *SSN for ACA purposes (Affordable Care Act)*
Step-Child(ren) Under Age 26	• ***AND** the appropriate dependent child documentation listed above*
Child(ren) under Legal Guardianship or Custody Under Age 26	• ***AND** court documents of the legal guardianship OR legal custody*
Child(ren) adopted or in the process of adoption Under Age 26	• ***AND** court documents of the legal adoption showing relationship to and placement in the employee's house **OR** adoption certificate issued through the courts*
Grandchild(ren) OR other children not related	• ***AND** State issued Birth Certificate(s) of child(ren) stating child was born to an insured dependent child of employee or spouse **OR*** • *Legal Guardianship/Custody/Document from the courts listing the employee or spouse as parent/legal guardian **AND*** • *SSN for ACA purposes (Affordable Care Act)*
Child(ren) Age 26 - 30	• ***AND** Overage Dependent Affidavit signed by employee*

All documentation must be either the original document or a notarized/certified copy of original document. Please note the Human Resources Division will need to view the original documents and will make copies for employer files.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim, or an application containing any false, incomplete, or misleading information is guilty of a felony of a third degree.

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

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

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

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) terminate 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 an 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)

IMPORTANT

If employee experiences a Qualifying Event the **Human Resources Division must be contacted within 30 days** of the Qualifying Event to make the appropriate changes to employee's coverage. 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. If approved, changes are effective on the first of the month following the Qualifying Event or date written request for change in coverage is received by the Human Resources Division. Newborns are effective on the date of birth and marriage is effective on the date of occurrence. Cancellations will be processed at the end of the month. In the event of death, coverage terminates the date following the death. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event."

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Benefit Offset

The City of Cocoa provides $100 per benefit payroll period to General Employees. The Benefit Off-Set will be used to help offset the cost of employee's benefits and any remaining funds will be put towards a City sponsored 457 Deferred Compensation benefit. With exception of FMLA or Military leave, employees on a continuous leave of absence without pay in excess of 30 days will not be eligible for this benefit.

Married Credit

Married couples who both work for the City of Cocoa and are eligible for City benefits are also eligible for the Married Credit. The Married Credit is an opportunity for married employees and dependent(s) to enroll in benefits under one (1) of the married employee's names for family coverage at no cost to either employee. This means that one of the two married employees may enroll with family coverage for medical, dental, and vision insurance at no cost. The other employee must opt-out of all benefits and also enroll for coverage under the employed spouse. The employee, who is opting out of all insurance plans, is not eligible for the opt-out benefit (see below). The employee who is enrolling all family members is required to enroll in the Core Plans available.

Opt-Out Benefit

If eligible employee is covered by another medical plan, and meets certain criteria as outlined below, the employee and eligible dependents have the opportunity to participate in the City's Employee Health Center. In the event the employee opts-out of participating in the City's group medical plan and declines participation in the Employee Health Center, the City will share a portion of monthly premium (an "Opt-out benefit"). The amount of the Opt-out benefit may vary from year to year.

For the plan year 2020-2021, the Opt-out benefit available is $100 per month. This benefit is paid in the employee's last check of each month, and is available to benefit-eligible employees covered under another qualified minimum value, minimum essential group or governmental insurance plan as described below. This option must be renewed each year, is not available to non benefit-eligible employees, and is considered taxable income to the employee. Employees receiving the "Married Credit" are not eligible for the Opt-out benefit.

As a result of recent legislative guidance, employee must provide proof that the employee, and all of employee's "tax dependents*", have enrolled or will enroll in "qualifying**" minimum value, minimum essential coverage (other than an individual insurance policy) for the plan year. A health coverage opt-out credit form must be completed and returned to the Human Resources Division with proof of coverage. This form can be found in Bentek.

**A "tax dependent" includes any person for whom the employee reasonably intends to claim a personal exemption on the employee's tax return during the tax year(s) that begins or ends during the City's medical insurance plan year. The City's medical plan year is October 1, 2020-September 30, 2021.*

***"Qualifying" coverage may could include Medicare, Medicaid, TRICARE, student health insurance, or a spouse's employer's group health plan providing minimum value.*

Default Benefits for the Dental and Vision Plans

Benefit-eligible employees will automatically be enrolled in employee only coverage for medical, dental and vision benefits, unless a different tier of coverage is selected. Changes to default benefits will not be permitted until the next applicable Open Enrollment period unless employee experiences a qualifying family status change (Qualifying Event).

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Employee Health Center

City of Cocoa Employee Health Center

The Employee Health Center (EHC) is available to employees, retirees, COBRA participants and eligible dependents enrolled in the City's medical insurance plan at no additional cost. If a benefit-eligible employee is covered by another medical plan, the employee and eligible dependents may utilize City's Employee Health Center.

- The EHC is also available to non benefit-eligible employees, along with eligible dependent(s), for a pre-tax monthly deduction of $100. Please contact the Human Resources Division for more details.

Employees who are not on the medical plan will have an opportunity to utilize the EHC per the options above at Open Enrollment only; mid-year changes will not be permitted.

The EHC provides the care employee and dependent(s) need for all non-emergency illnesses. Schedule an appointment with the medical staff to learn more about the Employee Health Center.

The EHC is administered by CareATC, a third-party vendor. Utilization is entirely voluntary. All visits with Employee Health Center staff are completely confidential and no personal information is shared with the City.

Why choose the Employee Health Center?

- ✓ Full range of primary care services available
- ✓ Online scheduling with dedicated 15-minute appointments
- ✓ 100% confidential and HIPAA compliant

What can be treated at the Employee Health Center?

- ✓ Cold & Flu, Sore Throat
- ✓ Labs & Medications
- ✓ Injections
- ✓ Minor Procedures
- ✓ Completion of Personal Health Assessment (PHA)
- ✓ Physicals
- ✓ Hypertension
- ✓ Cholesterol
- ✓ Diabetes
- ✓ Tobacco Cessation

**Certain medications are also available at the EHC at no cost; please schedule an appointment with a physician for more information.*

Hourly employees who utilize the EHC will also have up to six (6) visits each fiscal year without using leave hours.

How to Use the Employee Health Center:

- Call CareATC at 800-993-8244 to obtain a username and password for each participating member.
- Go to www.careatc.com and click Client Login.
- Enter username and password to access the secure User Menu.
- Schedule an appointment, view Personal Health Assessment, or edit personal data.
- Access CareATC's mobile website from any smartphone or download the app from the iPhone® or Android™ with just a tap! Visit a smartphone's app store and search for CareATC® to conveniently access medical history and schedule appointments.

Hours of operation are listed below. Appointments are **REQUIRED**; however, same day appointments may be accommodated based on availability and/or severity of issue.

Cocoa Health Center Hours of Operation

Day	Hours
Monday	7:30am - 11:30 am, 1:00pm - 5:00pm
Tuesday	8:00 a.m. - 12:00 p.m.
Wednesday	8:00 a.m. - 12:00 p.m., 1:30 p.m. - 5:30 p.m.
Thursday	8:00 a.m. - 12:00 p.m.
Friday	7:30 a.m. - 4:30 p.m.

The hours listed above are subject to change based on usage. The City will notify employees of any changes.

City of Cocoa | Employee Health Center
128 Lemon Street, Cocoa, FL 32922
Phone: (800) 993-8244 | patients.careatc.com

Satellite Beach Health Center Hours of Operation

Day	Hours
Monday	1:00 p.m.- 5:00 p.m.
Tuesday	1:00 p.m.- 5:00 p.m.
Wednesday	8:00 a.m. - 12:00 p.m.
Thursday	8:00 a.m. - 12:00 p.m.

The hours listed above are subject to change based on usage. The City will notify employees of any changes.

City of Satellite Beach | Employee Health Center
1087 S. Patrick Dr., Satellite Beach, FL 32937
(Located in the DRS Community Center complex)
Phone: (800) 993-8244 | patients.careatc.com

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Medical Insurance

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

Medical Insurance – Cigna Core Plan

24 Bi-Weekly Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + One	$167.33
Employee + Family	$328.36

Dependents Age 26-30

If covering an overage dependent (a dependent child who will reach age 27-30 during the year), please refer to the "Taxable Dependents" section on page 3 as employee may be subject to additional income tax.

Please note: Rates are based on the plan year October 1 to September 30. However, deductibles and annual maximums are January 1 to December 31.

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

Other Available Plan Resources

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

MotivateMe and Omada

Cigna's MotivateMe program is offered through the City of Cocoa and allows members to earn incentive points and rewarded with a Wellness Day Off. Employees can earn up to 300 incentive points when certain healthy activities are completed. For more details visit www.mycigna.com.

Members who have been diagnosed with pre-diabetes and qualify may participate in Omada. Omada is a personalized lifestyle program designed to help members make gradual changes, in eating, exercise, sleep and managing stress. This program is available at no additional cost to benefit-eligible employees and covered dependents. For more details, please visit omadahealth.com/cocoafl.

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 Open Enrollment. 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 Division
Address: 65 Stone Street
Cocoa, FL 32922
Phone: (321) 433-8440
Email: humanresources@cocoafl.org
Website URL: www.mybentek.com/cityofcocoa

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

If there are any questions about the plan offerings or coverage options, please contact the Human Resources Division at (321) 433-8440.

Telehealth

Cigna provides access to two (2) telehealth services as part of the medical plan at no cost to members. AmWell and MDLIVE are convenient phone and video consultation companies that provide immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is suggested and should be completed prior to using services. 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 Cigna.

Cigna
AmWell | Customer Service: (855) 667-9722 | www.AmWellforCigna.com
MDLIVE | Customer Service: (888) 726-3171 | www.MDLIVEforCigna.com

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Cigna Core Plan At-A-Glance

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	$2,000
Family	$6,000
Coinsurance	
Member Responsibility	20%
Calendar Year Out-of-Pocket Limit	
Single	$6,000
Family	$12,000
What Applies to the Out-of-Pocket Limit?	Coinsurance, Deductible, Copays, and Rx
Physician Services	
Primary Care Physician *(PCP)* through Employee Health Center	**No Charge**
Primary Care Physician *(PCP)* Office Visit *(No PCP Election Required)*	$25 Copay
Specialist Office Visit *(No Referral Required)*	$50 Copay
Telehealth Services	No Charge
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)* through Employee Health Center	**No Charge**
Clinical Lab *(Bloodwork)**	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT) - Per Scan, Per Day*	$100 Copay
Outpatient Surgery in Surgical Center	20% After CYD
Physician Services at Surgical Center	20% After CYD
Urgent Care *(Per Visit)*	$50 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)*	$250 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	20% After CYD
Outpatient Services *(Per Visit)*	No Charge
Outpatient Office Visit	$50 Copay
Prescription Drugs *(Rx)*	
Generic through Employee Health Center	**No Charge**
Generic	$20 Copay
Preferred Brand Name	$40 Copay
Non-Preferred Brand Name	$70 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 a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.*

Important Notes

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

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Dental Insurance

Cigna Dental PPO Plan

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

Dental Insurance – Cigna Dental PPO Plan
24 Bi-Weekly Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + One	$11.40
Employee + Family	$18.46

Default Benefits

Benefit-eligible employees will automatically be enrolled in employee only dental coverage, unless a different tier of coverage is selected. Changes to default benefits will not be permitted until the next applicable Open Enrollment period unless employee experiences a qualifying family status change (Qualifying Event).

In-Network Benefits

The Dental PPO 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 Cigna Total DPPO. 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 DPPO network. However, members that use the Cigna Advantage network will see additional cost savings from the added discount that is allowed for using an Advantage network provider. Members are responsible for verifying whether the treating dentist is an Advantage Dentist or a DPPO Dentist.*

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Cigna 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 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 Dental PPO plan requires a $25 individual or a $50 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

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

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

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Cigna Dental PPO Plan At-A-Glance

Network	Total Cigna DPPO	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$25	
Per Family	$50	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,500	
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 *(2 Per Calendar Year)*		
Complete X-rays *(Per 36 Months)*		
Bitewing X-rays *(2 Sets Per Calendar Year)*		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% 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: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$2,000	
Benefit *(Dependent Children and Adults)*	Plan Pays: 50% Deductible Waived	Plan Pays: 50% *(Subject to Balance Billing)* Deductible Waived

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 or Advantage** network.

Plan References

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

Important Notes

- *Each covered family member may receive up to two (2) routine cleanings per calendar year covered under the preventive benefit.*
- *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.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

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Vision Insurance

EyeMed Vision Care Plan

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

Vision Insurance – EyeMed Vision Care Plan
24 Bi-Weekly Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + Family	$2.37

Default Benefits

Benefit-eligible employees will automatically be enrolled in employee only vision coverage, unless a different tier of coverage is selected. Changes to default benefits will not be permitted until the next applicable Open Enrollment period unless employee experiences a qualifying family status change (Qualifying Event).

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, employees and covered dependent(s) may select any network provider who participates in the EyeMed Insight network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

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

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.

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

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EyeMed Vision Care Plan At-A-Glance

Network	Insight	
Services	**In-Network**	**Out-of-Network**
Eye Exam	No Charge	Up to $40 Reimbursement
Frequency of Services		
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses		
Single	No Charge	Up to $30 Reimbursement
Bifocal	No Charge	Up to $50 Reimbursement
Trifocal	No Charge	Up to $70 Reimbursement
Frames		
Allowance	Up to $150 Plus 20% Off Balance over $150	Up to $105 Reimbursement
Contact Lenses*		
Non-Elective *(Medically Necessary)*	No Charge	Up to $210 Reimbursement
Elective *(Fitting, Follow-up & Lenses)* – Conventional	Up to $150 Allowance Plus 15% Off Balance over $150	Up to $150 Reimbursement
Elective *(Fitting, Follow-up & Lenses)* – Disposable	Up to $150 Allowance Plus Balance over $150	Up to $150 Reimbursement

Locate a Provider

To search for a participating provider, contact EyeMed's customer service or visit www.eyemed.com. When completing the necessary search criteria, select **Insight** 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.*
- *Members receive additional fixed copayments on lens options including anti-reflective & scratch-resistant coatings.*
- *After copay, standard polycarbonate available at no charge for dependents less than 19 years old.*

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Flexible Spending Accounts

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

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

Health Care FSA

This account allows participant to set aside up to an annual maximum of $2,750. 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 adults.

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

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

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

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

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

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

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Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Employee may carry over up to $550 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed (only if the employee re-enrolls the next year). Dependent Care funds cannot be carried over.
- The Health Care FSA has a run out period at the end of the plan year (90 days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year (October 1 to September 30).
- Dependent Care FSA allows a grace period at the end of the plan year (75 days). 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.
- When a plan year ends and all claims have been filed with the exception of the $550 rollover for the Health Care FSA, all unused funds will be forfeited and not returned.
- Employee can enroll in either or both of the FSAs only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility period.
- 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 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 or fax. 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. TASC 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!

Employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $41.66 based on a 24 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

	With a Health Care FSA	Without a Health Care FSA
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**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the $550 carry over that may be allowed for the Health Care FSA.* ***This rule is known as "use-it or lose-it."***

TASC | Phone: (800) 422-4661 | Claims Fax: (608) 663-2754
www.tasconline.com

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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 Behavioral Health. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members 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 five (5) face-to-face, visits with a specialist, per person, per issue per year, telephonic consultation, online material/tools and webinars. EAP offers counseling services on issues such as:

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

Are Services Confidential?

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

To Access Services

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

Cigna Behavioral Health | Customer Service: (877) 622-4327
www.mycigna.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides Basic Term Life insurance for all eligible employees at no cost, through Cigna. The coverage amount will be determined by the following:

- Class I (Mayors) – Flat benefit amount of $50,000
- Class 2 (Full-Time Employees) – One (1) time base annual salary, up to a maximum of $100,000*
- Class 3 (Retirees) – Flat benefit amount of $10,000
- Class 4 (Executives) – Two (2) times base annual salary, up to a maximum of $200,000*

**If salary increases or decreases mid plan year, Life benefit amount will adjust at start of next plan year.*

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 65
- › Reduces to 50% of the benefit amount at age 70
- › Reduces to 35% of the benefit amount at age 75

Waiver of Premium Provision

In the event employee becomes disabled, employee may waive the premium for Life insurance. The waiver of premium provision applies to both the Basic and Voluntary coverages and also applies to coverages for the employee, spouse and dependent(s). There is a waiting period of six (6) months from the date that the employee's active service ends. The waiver of premium ends at age 70.

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

Cigna | Customer Service: (800) 732-1603 | www.mycigna.com

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Voluntary Life 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 Cigna. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages. Voluntary Life insurance offers coverage for employee, spouse or child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of the lesser of three times annual salary or $250,000** if employee is under age 65.

Please Note: *This does not include the Basic Life amount.*

- Units can be purchased in multiples of employee's annual salary (rounded up to the nearest $1,000), but cannot exceed the lesser of three (3) times annual salary or $300,000; the guaranteed issue amount is $250,000*.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70
  - Reduces to 35% of the benefit amount at age 75
- Coverage is $0.254 per $1,000 of coverage elected per month.
- AD&D coverage is $0.04 per $1,000 of coverage elected per month.

**If salary increases or decreases mid plan year, Life benefit amount will adjust at start of next plan year.*

Voluntary Family Benefit

- Employee must participate in the Voluntary Employee Life plan for family to participate.
- For legal spouses under the age of 70, there is a $5,000 benefit amount.
- For children 14 days to 19 years (up to 23 years of age, if unmarried and a full-time student) there is a $5,000 benefit amount.
- Coverage is a family rate of $1.37 per family unit per month.

Please Note: *Employees may choose either the Voluntary Family Life benefit or the separate Spouse and/or Dependent Child(ren) Life benefit, but not both.*

Voluntary Spouse Life and AD&D Insurance

New Hires may purchase Voluntary Spouse Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $30,000** if the spouse is under age 70.

- Employee must participate in Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $10,000 up to, not to exceed a maximum of $50,000, however coverage cannot exceed 50% of the employee's Voluntary Life coverage amount.
- Spouse coverage terms on 70th birthdate.
- Spouse Life coverage is $0.294 per $1,000 of coverage elected per month.
- Spouse AD&D coverage is $0.04 per $1,000 of coverage elected per month.

Dependent Child(ren) Life Insurance

- Employee must participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- For children who are less than six (6) months old there is a $500 benefit amount.
- For children six (6) months to 19 years (up to 23 years of age, if unmarried and a full-time student) there is a $10,000 benefit amount.
- Coverage is $0.184 per $1,000 for any eligible dependent child(ren) enrolled.
- Voluntary Dependent Child Life coverage does NOT include AD&D coverage.

Please Note: *Employees may choose either the Voluntary Family Life benefit or the separate Spouse and/or Dependent Child(ren) Life benefit, but not both.*

Cigna | Customer Service: (800) 732-1603 | www.mycigna.com

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Voluntary Short Term Disability

The City offers Voluntary Short Term Disability (STD) insurance to all eligible employees through Cigna. The STD benefit pays employee a percentage of the weekly earnings if employee becomes disabled due to an illness or non-work related injury (Workers Compensation will apply to work-related injury or illness).

Voluntary Short Term Disability (STD) Benefits

- STD provides a benefit of 60% of employee's weekly earnings up to a benefit maximum of $1,000 per week.
- Employee must be disabled for seven (7) consecutive days prior to becoming eligible for benefits (known as the elimination period). The elimination period is waived for accidents.
- Benefits will begin on the 1st day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 13 weeks.
- Employee deemed unable to return to work after the STD 13 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefit may be reduced by other income.
- Disability benefits are taxable.
- STD insurance coordinates with the City's Sick Leave benefits and is reduced by any amount payable to employee from other sources of income such as sick leave, sick leave bank, administrative leave, temporary duty elsewhere and social security. Employee may not receive more than 100% total of all combined income. Please check the City's current leave policy.

STD Insurance Rates

Monthly Rates per $10 of Weekly Benefit are listed below.

Age Bracket *(Based On Employee Age)*	Insurance Rate
< 45	$0.276
45 - 49	$0.322
50 - 54	$0.368
55 - 59	$0.488
60 - 64	$0.598
65 - 69	$0.681
70 – 74	$0.745
>75	$0.809

Calculation for Weekly Disability Benefit

$ ________ ÷ 52 = ________ X 60% = ________

Enter annual earnings | Weekly earnings | (Max % of income covered) | Max Eligible Amount. Round to nearest dollar. This amount cannot exceed $1,000

Calculation for Cost per Paycheck

$ ________ ÷ 10 = $ ________ X $ ________ = $ ________ X 12 = $ ________ ÷ 24 = $ ________

Max Eligible Amount | Rate | Your Monthly Cost | Annual Cost | Cost Per Paycheck

Cigna | Customer Service: (800) 732-1603 | File a Claim: (800) 362-4462 | www.mycigna.com

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Long Term Disability

The City provides Long Term Disability (LTD) insurance at no cost to all eligible employees through Cigna. The LTD benefit pays a percentage of monthly earnings if employee becomes disabled due to an illness or non-work related injury.

Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of $6,000 per month.
- Employee must be disabled for 90 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will commence on the 91st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The LTD maximum benefit period is determined based on age at the time of disability.
- LTD benefits will be offset with other income such as Social Security, Workers' Compensation, and retirement benefits, etc.
- LTD insurance coordinates with the City's sick leave benefits and is reduced by any amount payable to employee from other sources of income such as sick leave, sick leave bank, administrative leave, temporary duty elsewhere, social security and Workers' Compensation. Employee may not receive more than 100% total of all combined income. Please check the City's current leave policy.

Cigna | Customer Service: (800) 732-1603 | File a Claim: (800) 362-4462 | www.mycigna.com

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Voluntary Supplemental Insurance

Aflac offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums are paid by payroll deduction. During Open Enrollment for the 2020-2021 plan year Aflac will provide information on the following group supplemental products that provide cash benefits when employee or covered family member(s) become sick or injured.

- ✓ Accident Indemnity Plan
- ✓ Specified Critical Illness Plans (including Cancer, Stroke, and Heart Attack)
- ✓ Hospital Indemnity Plan

2020-2021 Aflac

24 Bi-Weekly Premium Deductions

Pre Tax Payroll Deductions

Plan Coverage	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Accident Indemnity Plan 24-Hour coverage on and off the job. Wellness $50 per covered person per calendar year payable after 12-months of coverage.	18+	$9.59	$14.43	$16.79	$21.63
Hospital Indemnity Inpatient, outpatient benefits, and physician visits.	18-64	$27.74	$54.09	$48.54	$74.89

After Tax Payroll Deductions

Specified Critical Illness Employee Uni-Rate	Age	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
$20K EE Guaranteed Issued including Cancer. Dependent child(ren) is automatically covered @25% of the primary insured amount. Wellness $50 per covered EE & spouse annually after 30-days of coverage.	18-29	$5.96	$8.66	$11.36	$14.06	$16.76	$19.46	$22.16	$24.86	$27.56
	30-39	$5.96	$8.66	$11.36	$14.06	$16.76	$19.46	$22.16	$24.86	$27.56
	40-49	$11.36	$16.76	$22.16	$27.56	$32.96	$38.36	$43.76	$49.16	$54.56
	50-54	$16.45	$24.28	$32.10	$39.93	$47.75	$55.58	$63.40	$71.23	$79.05
	55-59	$22.05	$32.68	$43.30	$53.93	$64.55	$75.18	$85.80	$96.43	$107.05
	60-64	$30.55	$45.43	$60.30	$75.18	$90.05	$104.93	$119.80	$134.68	$149.55
	65-69	$33.25	$49.48	$65.70	$81.93	$98.15	$114.38	$130.60	$146.83	$163.05

After Tax Payroll Deductions

Specified Critical Illness Spouse Uni-Rate	Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
$10K Spouse Guaranteed Issued including Cancer. Wellness $50 per covered EE & spouse annually after 30-days of coverage.	18-29	$3.26	$4.61	$5.96	$7.31	$8.66	$10.01	$11.36	$12.71	$14.06
	30-39	$3.26	$4.61	$5.96	$7.31	$8.66	$10.01	$11.36	$12.71	$14.06
	40-49	$5.96	$8.66	$11.36	$14.06	$16.76	$19.46	$22.16	$24.86	$27.56
	50-54	$8.63	$12.54	$16.45	$20.36	$24.28	$28.19	$32.10	$36.01	$39.93
	55-59	$11.43	$16.74	$22.05	$27.36	$32.68	$37.99	$43.30	$48.61	$53.93
	60-64	$15.68	$23.11	$30.55	$37.99	$45.43	$52.86	$60.30	$67.74	$75.18
	65-69	$17.03	$25.14	$33.25	$41.36	$49.48	$57.59	$65.70	$73.81	$81.93

Aflac | Customer Service: (800) 433-3036 | www.aflac.com
Agent: Margaret Pearson | Phone: (561) 881-1964 | Email: margaret_pearson@us.aflac.com

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Legal & Identity Theft Plan

Premium Schedule: 24 Bi-Weekly Premium Deductions	
Family Defender Plan	$9.38
Identity Defender	$4.98

Family Defender Legal Plan

The City offers employees the opportunity to participate in a voluntary legal insurance program provided by the U.S. Legal Services. By enrolling in this plan, participants will have direct access to attorneys who will provide legal assistance 24 hours a day, seven (7) days a week for a variety of situations that include:

- ✓ Divorce
- ✓ Adoption
- ✓ Civil Litigation
- ✓ Child Custody and Support
- ✓ Bankruptcy
- ✓ Name Changes
- ✓ Criminal Defense
- ✓ Traffic Tickets
- ✓ Wills & Living Trusts
- ✓ Real Estate
- ✓ Credit Report Issues
- ✓ Contract Review

The cost to the employee to participate in this legal plan is $18.75 per month. This includes coverage for the entire household including a spouse and dependent children up to age 26 regardless of the number of eligible dependents enrolled in the plan. Plan benefits include unlimited access to an online document library, unlimited telephone consultations, face-to-face consultations with attorneys, review of legal documents, letters/phone calls to third parties on the participant's behalf and much more. To learn about the plan, contact the City's U.S. Legal Services representative, Dixie Kuehn, at (321) 799-2986 or email at dixiekuehn@cfl.rr.com.

Identity Defender

U.S. Legal Services offers an identity benefit that protects you and your family against Identity Theft. With the Identity Defender Plan, your family can fight back against stolen identity and can restore your good credit and your stolen funds. Certified Protection Experts available to assist with identity theft matters 24/7. Experts complete all paperwork and make all calls to ensure your identity is restored. Members have access to an online dashboard and mobile app for continuous monitoring and alerts. Covered identity services include, but are not limited to:

- Advanced Fraud Monitoring
- Change of Address Monitoring
- Credit & Debit Card Monitoring
- Dark Web Monitoring*
- Fraud Alert Reminders
- Medical ID Fraud Protection
- Smart SSN Tracker*
- Lost Wallet
- Stolen Funds Reimbursement
- Identity Theft Insurance ($1 million)*
- Identity Restoration*
- Credit Monitoring
- Mobile App
- Two Adults & Unlimited Dependent Children Covered**

*Covered for dependents under ChildWatch

**Dependents must be under 26 years old and live in the policy holder's residence.

U.S. Legal Services
Agent: Dixie Kuehn | Phone: (321) 403-0156 | Email: dixiekuehn@cfl.rr.com
www.uslegalservices.net

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Deferred Compensation 457(b)

The City offers a voluntary 457 Deferred Compensation retirement savings plan through either the International City Management Association (ICMA) or Nationwide*. A 457 plan is a supplemental retirement savings program that allows employee to make contributions on a pre-tax basis. Federal, and in most cases, State income taxes (Florida does not have a State income tax) are deferred until assets are withdrawn, usually during retirement when employee may be in a lower tax bracket. A summary of the 457 plan's benefits are provided below.

- Employee can reduce current income taxes while investing for retirement.
- Employee earnings accumulate tax-deferred.
- Employee can dollar cost average** through convenient payroll deductions.
- Employee may be allowed to make additional "catch-up" contributions if employee is 50 (or older) or within three (3) years of normal retirement age and already contributing the maximum to the plan.
- If there is a job change, employee has the flexibility to move account into employee's new Employer's retirement plan.
- If employee retires early, but at least at the age of 59 1/2, there is no penalty for withdrawals.

457 Plans Advantages Include:

- Ability to increase, decrease, stop and restart contributions as employee wishes without fees or penalties.
- Choose from a wide range of investment options selected by employer for the plan. There are no restrictions or charges for reallocating investment mix within a reasonable limit and all funds offered are no-load.
- There are no minimum investment requirements.
- Employee's designated beneficiaries are entitled to receive all remaining funds in employee's account in the event of death (Less any applicable taxes and/or penalties).
- Flexible withdrawal payment options are available. Employee can determine the payment schedule that is right for them.

There are strict Internal Revenue Code limits to the amount an employee may contribute each year. There are two (2) "Catch-Up" provisions that allow employee to contribute over-and-above the normal annual contribution amount. However, employee will pay taxes on the amount withdrawn and are required to begin withdrawing from the account by a certain age.

**Nationwide and ICMA offer loans under certain circumstances. See plan representative for more details.*

***Since dollar cost averaging involves continuous investing, regardless of fluctuating prices, investors must consider their level of comfort in continuing to invest during a declining market. Dollar cost averaging does not assure profit or protect against loss in a declining market.*

Nationwide Retirement Solutions
Customer Service: (877) 677-3678 | www.nrsforu.com

ICMA Retirement Corporation
Customer Service: (800) 669-7400 | www.icmarc.org

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Notes

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

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