City of Lake Worth Beach℠ FLORIDA

Employee Benefit Highlights 2022-2023

Photos courtesy of Nicola Lugo

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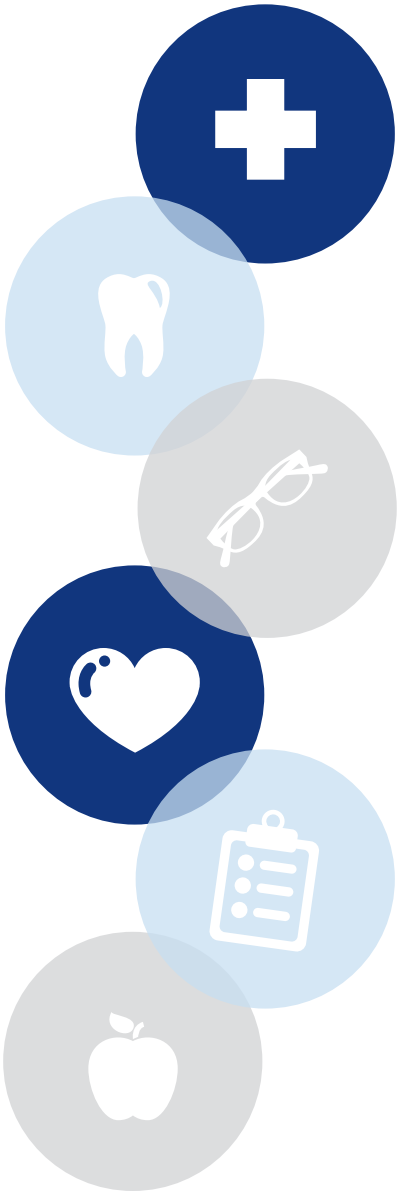


This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Lake Worth Beach reserves the right to amend, modify or terminate the plan at any time.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

Contact Information

	Human Resources Department		Phone: (561) 586-1658
	Online Benefit Enrollment	Bentek Support	(888) 5-Bentek (523-6835) Email: support@mybentek.com www.mybentek.com/cityoflakeworthbeach
	Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Cigna/Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
	Telehealth	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.mycigna.com
	Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	Eyemed	Customer Service: (866) 939-3633 www.eyemed.com
	FSA Administrator	Benefits Workshop	Customer Service: (888) 537-3539 Fax: (904) 880-2830 www.benefitsworkshop.com/lakeworthbeach
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Voluntary Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Voluntary Short Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Voluntary Long Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Employee Assistance Program	Cigna Behavioral Health	Customer Service: (877) 622-4327 www.mycigna.com
	Supplemental Insurance	Cigna	Customer Service: (800) 754-3207
	457 Deferred Compensation	MissionSquare Retirement formerly ICMA-RC	Customer Service: (800) 669-7400
	Claims, Billing & Benefit Assistance	Gehring Group	Phone: (800) 244-3696 Email: lakeworthbeach@gehringgroup.com

City of Lake Worth Beach℠ FLORIDA

Introduction

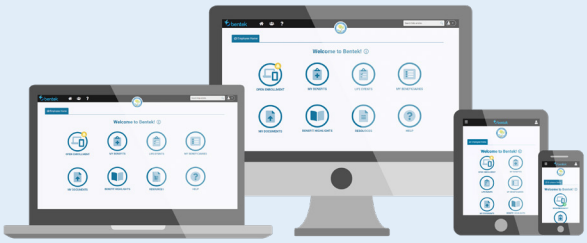
The City provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the the City's Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available 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 Department for further information.

To access Bentek using a mobile device, scan code:

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/cityoflakeworthbeach**
- ✓ 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/cityoflakeworthbeach

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

Group Insurance Eligibility

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

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first of the month following date of hire. For example, if employee is hired on April 11, then the effective date of coverage will be May 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/domestic partner and/or dependent child(ren) of the participant or spouse/domestic partner. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A stepchild
- A newborn child (up to the age of 18 months old) 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 dependents over age 26.

Dependent Age Requirements *(Continued)*

Dental and Vision Coverage: A dependent child may be covered through end of calendar year in which child turns age 30.

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's insurance plan; and
- The dependent has been continuously insured

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

Taxable Dependents

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

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

Group Insurance Eligibility *(Continued)*

Domestic Partner Coverage

Domestic partners may be eligible to participate in the City's group insurance plans if the partner is officially registered as a domestic partner with the City. The IRS guidelines state that employee may not receive a tax advantage on any portion of premiums paid related to domestic partner coverage. Employees insuring domestic partners and/or child dependent(s) of a domestic partner are required to pay imputed income tax on subsidy amounts and should consult a tax advisor. Please see Human Resources Department for more information.

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

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

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

Examples of Qualifying Events:

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

IMPORTANT NOTES

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

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 plan, please refer to Cigna's Summary of Benefits and Coverage (SBC) document or contact Cigna's customer service.

Medical Insurance – Cigna OAPIN Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	Employer Cost
Employee Only	$0	$384.89
Employee + Spouse	$140.77	$654.46
Employee + Child(ren)	$115.67	$606.70
Employee + Family	$286.12	$915.62

Summary of Benefits and Coverage

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

From:	Human Resources Department
Address:	7 North Dixie Highway Lake Worth Beach, FL 33460
Phone:	(561) 586-1658
Website URL:	www.mybentek.com/cityoflakeworthbeach

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 Department.

If there are any questions about the plan offerings or coverage options, please contact the Human Resources Department at (561) 586-1658.

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.

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

Telehealth

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

The benefit is provided to all enrolled members. Registration is 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
- ✓ Fever
- ✓ Rash
- ✓ Headache
- ✓ Cold And Flu
- ✓ Acne
- ✓ Stomachache
- ✓ Allergies
- ✓ UTIs And More

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

Cigna

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

Cigna OAPIN Plan At-A-Glance

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	$2,000
Family	$4,000
Coinsurance	
Member Responsibility	20%
Calendar Year Out-of-Pocket Limit	
Single	$7,150
Family	$14,300
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$35 Copay
Specialist Office Visit	$70 Copay
Telehealth Services	$35 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)**	20% After CYD
X-rays	20% After CYD
Advanced Imaging *(MRI, PET, CT)*	$500 Copay
Outpatient Surgery in Surgical Center	20% After CYD
Physician Services at Surgical Center	20% After CYD
Urgent Care *(Per Visit)*	$60 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)*	$350 After CYD
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospitalization *(Per Admission)*	20% After CYD
Outpatient Services *(Per Visit)*	20% After CYD
Outpatient Office Visit	$70 Copay
Prescription Drugs *(Rx)*	
Generic	$20 Copay
Preferred Brand Name	$50 Copay
Non-Preferred Brand Name	$100 Copay
Specialty Drug	$20/$50/$100
Mail Order Drug *(90-Day Supply)*	2.5x 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.*

Dental Insurance

Cigna DHMO 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 DHMO Plan

24 Pay Period Premium Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	Employer Cost
Employee Only	$0	$9.19
Employee + Spouse	$5.84	$11.05
Employee + Child(ren)	$8.58	$12.12
Employee + Family	$15.18	$15.23

In-Network Benefits

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

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

Out-of-Network Benefits

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

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Benefit Maximum

There is no benefit maximum.

IMPORTANT NOTES

- *Each covered family member may receive up to two (2) routine cleanings per plan year covered under the preventive benefit. Members can also receive two (2) additional cleanings at the charge of a copay.*
- *Prior authorization is not required for specialty referrals for Endodontic, Orthodontic and Pediatric Services.*
- *Waiting periods and age limitations may apply.*

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

Cigna DHMO Plan At-A-Glance

Network	Cigna Dental Care Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Class I Services: Diagnostic & Preventive Care*	**Code**	**In-Network**
Routine Oral Exam *(2 Per Year)*	0120	Plan Pays: 100% Deductible Waived
Routine Cleanings *(2 Per Year)*	1110	
Complete X-ray *(1 Every 3 Years)*	0210	
Bitewing X-rays *(2 Per Year)*	0274	
Class II Services: Basic Restorative Care*		
Fillings *(Amalgam)*	2160	$0
Fillings *(Resin, 3 Surface Posterior)*	2393	$65
Simple Extractions *(Erupted Tooth or Exposed Root)*	7210	$25
Root Canal Therapy *(Molar)***	3330	$195
Surgical Removal of Tooth *(Impacted)*	7240	$80
Full Mouth Debridement	4355	$35
Class III Services: Major Restorative Care*		
Crowns *(Porcelain Fused to Metal)*	6750	$130
Bridges *(Porcelain Fused to Metal)*	6240	$130
Dentures	5110/20	$135 + Labs
Class IV Services: Orthodontia*		
Benefit - Child/Adult	8670	$1,224 / $1,728
Treatment Planning/Records	8660	$85
Retention	8680	$270

Locate a Provider

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

Plan References

**Office visits are subject to a $5 copay regardless of what service is rendered per visit.*

*** Excluding final restoration*

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 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	Employer Cost
Employee Only	$5.87	$9.11
Employee + Spouse	$17.92	$9.73
Employee + Child(ren)	$27.38	$10.25
Employee + Family	$46.39	$11.25

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 Total Cigna 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 members receive services by a non-participating Total Cigna 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 $50 individual or a $150 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the Dental PPO plan will pay for each covered member is $1,000 for in-network and out-of-network services combined. All services, including preventive, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

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

Cigna Dental PPO Plan At-A-Glance

Network	Total Cigna DPPO	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Year)*		
Complete X-ray *(1 Every 3 Years)*		
Bitewing X-rays *(2 Sets Per Year)*		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Oral Surgery		
Periodontal Services		
Anesthetics		
Class III Services: Major Restorative Care		
Endodontics *(Root Canal Therapy)*	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Crowns		
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,500	
Benefit *(Dependent Children Up To Age 19)*	Plan Pays: 50% Deductible Waived	Plan Pays: 50% Deductible Waived *(Subject to Balance Billing)*

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.*
- *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 Cigna's customer service.*

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 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	Employer Cost
Employee Only	$0	$2.85
Employee + Spouse	$2.86	$2.85
Employee + Child(ren)	$1.99	$2.85
Employee + Family	$5.13	$2.85

In-Network Benefits

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

Out-of-Network Benefits

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

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

EyeMed Vision Care Plan At-A-Glance

Network		Insight	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 copay	Up to $40 Reimbursement
Contact Lens Fit & Follow-Up	Standard Lens	Up to $40 Allowance	Not Covered
	Premium Lens	10% Off Retail Price	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		$25 Copay	Up to $30 Reimbursement
Bifocal		$25 Copay	Up to $50 Reimbursement
Trifocal		$25 Copay	Up to $70 Reimbursement
Frames			
Allowance		$150 Retail Allowance; Then 20% Off Balance Over $150	Up to $105 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $210 Reimbursement
Elective *(Lenses)*	Conventional	$150 Allowance; Then 15% Off Balance Over $150	Up to $150 Reimbursement
	Disposable	$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.

Flexible Spending Accounts

The City offers Flexible Spending Accounts (FSA) administered through Benefits Workshop. The FSA plan year is from October 1 through 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 $2,850. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

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

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

Dependent Care FSA

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

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

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

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

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- The Health 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.
- 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).
- When a plan year ends and all claims have been filed, all unused funds will be forfeited and not returned.
- Employee can enroll in an FSA 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. Benefits Workshop may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the City. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $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 $197.

	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 19.65% = 12% + 7.65% FICA	- $5,698	- $5,895
After Tax Expenses	- $0	- $1,000
Spendable Income	$23,302	$23,105
Tax Savings	**$197**	

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

Benefits Workshop | Phone: (888) 537-3539 | Fax: (904) 880-2830
http://benefitsworkshop.com/lakeworthbeach

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 New York Life. Eligible employees will receive a benefit amount of $25,000.

Accidental Death & Dismemberment Insurance

Also, at no cost to the employee, the City provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit. A partial benefit is also payable based on the summary of benefits. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact Cigna's customer service.

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 25% of the benefit amount at age 75

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

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

Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

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

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $100,000.**

- Units can be purchased in increments of $10,000 to the maximum of $300,000.

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 25% of the benefit amount at age 75

2022-2023 Open Enrollment: Eligible employees have the opportunity to purchase Voluntary Employee Life and AD&D insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $100,000.

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**.

- Employee must participate in Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $5,000 to a maximum of $100,000 not to exceed 50% of the employee's Voluntary Life coverage amount.

2022-2023 Open Enrollment: Eligible employees have the opportunity to purchase Voluntary Spouse Life and AD&D insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $30,000.

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 25% of the benefit amount at age 75

Voluntary Dependent Child(ren) Life Insurance

- Employee must participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- Employee may elect coverage in a flat amount of $10,000.
- Child(ren) from birth to six (6) months may be covered for a maximum benefit of $500.

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

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

Voluntary Short Term Disability

The City offers Voluntary Short Term Disability (STD) insurance to all eligible employees through New York Life. 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 ill or incur a non-work related injury for 14 days prior to becoming eligible for benefits (known as the elimination period). The elimination period is waived for accidents.
- Benefits will begin on the 15th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 11 weeks.
- Employee deemed unable to return to work after the STD 11 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- The benefit amount will be offset by any other income received. Employee may not receive more than 60% total of all income combined.

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

Voluntary Long Term Disability

The City offers Voluntary Long Term Disability (LTD) insurance to all eligible employees through New York Life. The LTD benefit pays a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Voluntary Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of $5,000 per month.
- Employee must be disabled for 90 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin 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 maximum benefit period is determined based on age at the time of disability.
- The benefit amount will be offset by any other income received. Employee may not receive more than 60% total of all income combined.

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

Employee Assistance Program

The City cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Cigna Behavioral Health. EAP offers employee and each household 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 household family members/domestic partners free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes three (3) 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/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 | Employer ID: COLW

Wellness Program

The City of Lake Worth Beach is committed to wellness and good health. The goal is to promote wellness activities that will engage employees to develop or maintain a healthy lifestyle. The City will provide employees with resources and tools that will allow them to maximize their well-being and the overall health of their family.

Wellness is a state of well-being and process that applies to the "whole person". Human beings aren't one dimensional — our lives comprise many facets including social, physical, environmental, spiritual, psychological, occupational, behavioral and financial.

The City's wellness activities will include health related seminars and workshops on topics such as diabetes education, hypertension management, high blood pressure support and management, cholesterol education, healthy eating, exercise and weight management, in addition to other subjects including stress management, family/work life balance, retirement, financial and safety.

For more information regarding the City's Wellness Program please visit https://employee.lakeworthbeachfl.gov/wellness/

Supplemental Insurance

Cigna offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid via payroll deduction. Cigna pays money directly to members, regardless of what other insurance plans they may have.

Group Accident Insurance

Helps to offset the unexpected medical expenses, such as emergency room fees, deductibles and copayments, that can result from a fracture, dislocation or other covered accidental injury. Off Job and On/Off Job coverage available.

Group Critical Illness Insurance

Compliments existing major medical coverage by providing a lump-sum benefit that can be used to pay the direct and indirect costs related to a covered critical illness, which can often be expensive and lengthy.

Group Hospital Indemnity Insurance

Provides a lump-sum benefit for a covered hospital confinement and a covered outpatient surgery to help offset the gaps caused by copayments and deductibles that are not covered by most major medical plans.

Cigna's coverage features:

- Group coverage is available for a members' spouse and children with most products.
- Benefits are paid directly to members, unless specified otherwise.
- With most plans, members will be able to continue group coverage when they retire or change jobs, with no increase in premium.
- With most plans, members will receive benefits regardless of any other insurance members may have with other insurance companies.

Cigna | Benefit Information: (800) 351-9214
Member Services/Claims: (800) 754-3207
www.cigna.com

Optional Retirement Plans

457 Deferred Compensation Plan

The Deferred Compensation Plan administered by MissionSquare Retirement formerly ICMA-RC provides unique advantages over regular savings plans. Employee's Deferred Compensation deposits can grow faster than regular savings because their growth is deferred. That is, an employee does not pay any taxes on either the money saved or the earnings until they retire. These tax advantages make Deferred Compensation an ideal additional retirement savings plan, supplementing the City's Plan(s).

Employees are eligible to participate in the 457 plan with salary deferrals, immediately upon being hired. Employee may enroll anytime during the year; they do not need to wait upon open enrollment. Salary deferrals are allowed to the annual maximum limits imposed by the IRS. For 2022, the limit is $20,500; Age 50 Catch Up is $6,500.

Loans are not permitted.

Additional Features

Double Catch-Up

Eligible employees may participate in the "Double Catch-Up provision set by the IRS that allow participants who are within three (3) years of attaining the normal retirement age to contribute up to twice the annual contribution limit. Participants who use this catch-up limit cannot also use "Age 50" Catch Up limit in the same year.

Pay Out of Accrued Time

When an employee leaves their employment with the City, accrued eligible vacation and sick hours are considered eligible compensation and employee may have compensation paid out and applied to their 457 Deferred Compensation retirement account.

Roth Individual Retirement Account (IRA)

The Roth IRA are funded by after tax contributions of up to a maximum set by the IRS. The maximum contribution for 2022 is $6,000 and the Age 50 Catch-Up limit is $1,000 totaling $7,000. Because taxes are paid up front, distributions are tax free on the principal amount as well as the earnings.

Contributions can be made either by payroll deductions or deposits made by the employee directly into their account.

Loans are permitted.

For additional information, please contact MissionSquare Retirement at (800) 669-7400.

MissionSquare Retirement formerly ICMA-RC
Customer Service: (800) 669-7400

Claims, Billing & Benefit Assistance

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

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

Employee may contact a claims specialist by:

1. Email: lakeworthbeach@gehringgroup.com

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

OR

2. Call: (800) 244-3696

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

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

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

Notes

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

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City of Lake Worth Beach℠ FLORIDA

GEHRING GROUP
A RISK STRATEGIES COMPANY

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

To access benefit booklet, use a mobile device to scan code.

FINAL
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