

2021 EMPLOYEE BENEFIT HIGHLIGHTS

The Town of Davie strives to be the preminent community in South Florida to live, work, learn, and play while treasuring our preserved natural settings.



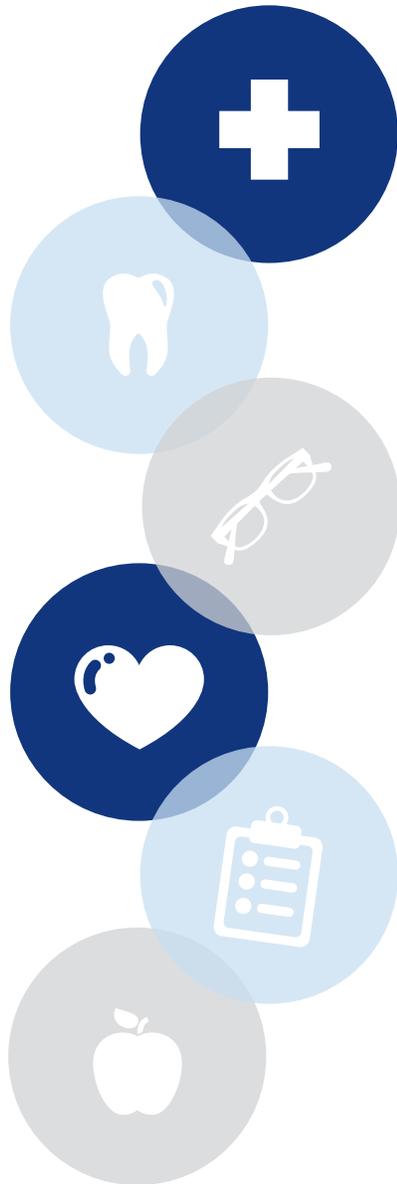


Contact Information

	Human Resources Department		Phone: (954) 797-1100
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) www.mybentek.com/davie
	Medical Insurance	UnitedHealthcare	Customer Service: (800) 357-0978 www.myuhc.com
	Prescription Drug Coverage & Mail-Order Program	Optum Rx	Customer Service: (888) 739-5820 www.optumrx.com
	Health Savings Account	UnitedHealthcare	Customer Service: (800) 357-0978 www.myuhc.com
	Virtual Visits	UnitedHealthcare	Customer Service: (800) 357-0978 www.myuhc.com
	Dental Insurance	Humana	Customer Service: (800) 233-4013 www.humana.com
	Vision Insurance	Humana	Customer Service: (800) 233-4013 www.humana.com
	Flexible Spending Accounts	WageWorks	Customer Service: (800) 950-0105 www.takecarewageworks.com
	Basic Life and AD&D Insurance	The Standard	Customer Service: (800) 628-8600 www.standard.com
	Voluntary Life Insurance	The Standard	Customer Service: (800) 628-8600 www.standard.com
	Short Term Disability Insurance	The Standard	Customer Service: (800) 368-2859 www.standard.com
	Long Term Disability Insurance	The Standard	Customer Service: (800) 368-1135 www.standard.com
	Employee Assistance Program	UnitedHealthcare	Customer Service: (888) 887-4114 www.myuhc.com
	Supplemental Insurance	Aflac	Agent: Gene Villa Phone: (561) 714-4224 Customer Service: (800) 992-3522 www.aflac.com
		Colonial Life	Agent: Donna Tilton Phone: (954) 829-4930 Customer Service: (800) 325-4368 www.coloniallife.com
	Pet Insurance	Nationwide	Customer Service: (877) 738-7874 www.petinsurance.com/affiliates/davieflgov
	Legal Insurance	LegalShield	Agent: Yvette Mayo Cell Phone: (407) 719-4897 Customer Service: (877) 825-3797 www.legalshield.com/info/townofdavie
		U.S. Legal	Agent: Dixie Kuehn Phone: (321) 403-0156 Customer Service: (800)356-LAWS www.uslegalservices.net
	Retirement	VOYA Retirement	Customer Service: (800) 548-6001 www.VOYA.com

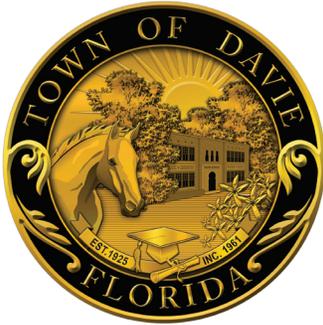


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This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The Town of Davie reserves the right to amend,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



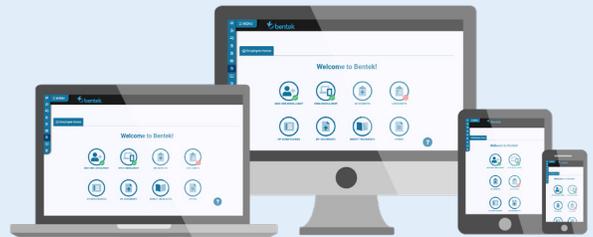
Introduction

The Town of Davie 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 Town'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.

Online Benefit Enrollment

The Town 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/davie
- ✓ 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/davie

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 Town's group insurance plan year is January 1 through December 31.

Employee Eligibility

Employees are eligible to participate in the Town'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 30 days of employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 1.

Separation of Employment

If employee separates employment from the Town, 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 stepchild
- A legally adopted child
- 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.

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

Disabled Dependents

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

- The dependent is physically or mentally disabled and incapable of self-sustaining employment; 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 Department if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under employee's medical 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.



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. 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 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. Cancellations will be processed at the end of the month. In the event of death, coverage terminates the day following the death. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Summary of Benefits and Coverage

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

From:	Human Resources Department
Address:	6591 Orange Drive Davie, FL 33314
Phone:	(954) 797-1100
Website URL:	www.mybentek.com/davie

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 (954) 797-1100.



Medical Insurance

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

Medical Insurance – UHC EPO Choice Plus Plan

24 Payroll Deductions - Per Pay Period Premium

Tier of Coverage	Employee Cost
Employee Only	Please see page 26 for plan cost and benefit choice dollars allowance.
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	

Medical Insurance – UHC POS Choice Plus Plan

24 Payroll Deductions - Per Pay Period Premium

Tier of Coverage	Employee Cost
Employee Only	Please see page 26 for plan cost and benefit choice dollars allowance.
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	

Medical Insurance – UHC HDHP Choice Plus Plan

24 Payroll Deductions - Per Pay Period Premium

Tier of Coverage	Employee Cost
Employee Only	Please see page 26 for plan cost and benefit choice dollars allowance.
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	

UnitedHealthcare | Customer Service: (800) 357-0978 | www.myuhc.com

Benefit Choice Dollars

The Town offers funding through “Benefit Choice Dollars” to all benefit-eligible employees. These Benefit Dollars are to be used to contribute to the cost of insurance premiums each employee incurs. The employee may choose which plans they would like them to be applied.

Other Available Plan Resources

UnitedHealthcare offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please contact UnitedHealthcare's customer service at (800) 357-0978, or visit www.myuhc.com.

UHC Health4me Mobile App

The UHC “Health4me” mobile app gives users access to ID cards (which can be directly emailed or faxed to a doctor), providers within the UHC Network (locator works with a phone's GPS), “Easy Connect” for claims and benefit questions, registered nurses and the ability to check status of deductible and out-of-pocket limit. Health4me is available on iPhone® and Android®. Find more information on www.uhc.com and select Health4me.

Real Appeal

Real Appeal is a comprehensive online weight loss program that teaches members how to take small, manageable steps that lead to a healthier body and lifestyle. This program is free for qualified employees who are on the medical plan. Members can enroll at we.realappeal.com.

Virtual Visits

UnitedHealthcare provides access to virtual visits as part of the medical plan. Virtual Visits is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. 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. Virtual Visits 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 Virtual Visits, such as:

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

Virtual Visits 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 UnitedHealthcare.

UnitedHealthcare | Customer Service: (800) 357-0978 | www.myuhc.com



UHC Choice Plus EPO Choice Plus Plan At-A-Glance



Locate a Provider

To search for a participating provider, contact UnitedHealthcare's customer service or visit www.myuhc.com. When completing the necessary search criteria, select Choice Plus network.



Plan References

***Out-Of-Network Balance Billing:**

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

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

Network	Choice Plus	
Calendar Year Deductible (CYD)	In-Network	Out of Network*
Single	\$0	\$7,500
Family	\$0	\$15,000
Coinsurance		
Member Responsibility	0%	50%
Calendar Year Out-of-Pocket Limit		
Single	\$2,600	\$10,000
Family	\$5,200	\$20,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays, and Rx	
Physician Services		
Primary Care Physician (PCP) Office Visit	\$20 Copay	50% After CYD
Specialist Office Visit***	Tier 1: \$30 / Non-Tier 1:\$40 Copay	50% After CYD
Virtual Visits	\$15 Copay	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab (Bloodwork)**	No Charge	50% After CYD
X-rays	No Charge	50% After CYD
Advanced Imaging (MRI, PET, CT)	\$150 Copay	50% After CYD
Outpatient Surgery in Surgical Center	\$200 Copay	50% After CYD
Physician Services at Surgical Center	No Charge	50% After CYD
Urgent Care (Per Visit)	\$30 Copay	50% After CYD
Hospital Services		
Inpatient Hospital (Per Admission)	\$300 Copay	50% After CYD
Outpatient Hospital (Per Visit)	\$200 Copay	50% After CYD
Physician Services at Hospital	No Charge	50% After CYD
Emergency Room (Per Visit)	\$200 Copay	\$200 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services (Per Admission)	\$300 Copay	50% After CYD
Outpatient Services (Per Visit)	\$20 Copay	50% After CYD
Prescription Drugs (Rx)		
Tier 1	\$10 Retail Copay	\$10 Retail Copay
Tier 2	\$30 Retail Copay	\$30 Retail Copay
Tier 3	\$50 Retail Copay	\$50 Retail Copay
Mail Order Drug (90-Day Supply)	2x Retail Copay	Not Covered



UHC Choice Plus POS Choice Plus Plan At-A-Glance

Network	Choice Plus	
Calendar Year Deductible (CYD)	In-Network	Out of Network*
Single	\$250	\$500
Family	\$500	\$1,000
Coinsurance		
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Limit		
Single	\$2,700	\$3,000
Family	\$5,400	\$6,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays, and Rx	
Physician Services		
Primary Care Physician (PCP) Office Visit	\$20 Copay	40% After CYD
Specialist Office Visit***	Tier 1: \$30 / Non-Tier 1:\$40 Copay	40% After CYD
Virtual Visits	\$15 Copay	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab (Bloodwork)**	20% After CYD	40% After CYD
X-rays	20% After CYD	40% After CYD
Advanced Imaging (MRI, PET, CT)	20% After CYD	40% After CYD
Outpatient Surgery in Surgical Center	20% After CYD	40% After CYD
Physician Services at Surgical Center	20% After CYD	40% After CYD
Urgent Care (Per Visit)	\$30 Copay	40% After CYD
Hospital Services		
Inpatient Hospital (Per Admission)	20% After CYD	40% After CYD
Outpatient Hospital (Per Visit)	20% After CYD	40% After CYD
Physician Services at Hospital	20% After CYD	40% After CYD
Emergency Room (Per Visit)	\$200 Copay	\$200 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services (Per Admission)	20% After CYD	40% After CYD
Outpatient Services (Per Visit)	\$20 Copay	40% After CYD
Prescription Drugs (Rx)		
Tier 1	\$10 Retail Copay	\$10 Retail Copay
Tier 2	\$30 Retail Copay	\$30 Retail Copay
Tier 3	\$50 Retail Copay	\$50 Retail Copay
Mail Order Drug (90-Day Supply)	2x Retail Copay	Not Covered



Locate a Provider

To search for a participating provider, contact UnitedHealthcare's customer service or visit www.myuhc.com. When completing the necessary search criteria, select Choice Plus network.



Plan References

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

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



UHC Choice Plus HDHP Choice Plus Plan At-A-Glance



Locate a Provider

To search for a participating provider, contact UnitedHealthcare's customer service or visit www.myuhc.com. When completing the necessary search criteria, select Choice Plus network.



Plan References

***Out-Of-Network Balance Billing:**

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

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

Network	Choice Plus	
Calendar Year Deductible (CYD)	In-Network	Out of Network*
Single	\$1,400	\$3,300
Family	\$2,800	\$6,600
Coinsurance		
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Limit		
Single	\$2,700	\$5,000
Family	\$5,400	\$10,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays, and Rx	
Physician Services		
Primary Care Physician (PCP) Office Visit	20% After CYD	40% After CYD
Specialist Office Visit	20% After CYD	40% After CYD
Virtual Visits	20% After CYD	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab (Bloodwork)**	20% After CYD	40% After CYD
X-rays	20% After CYD	40% After CYD
Advanced Imaging (MRI, PET, CT)	20% After CYD	40% After CYD
Outpatient Surgery in Surgical Center	20% After CYD	40% After CYD
Physician Services at Surgical Center	20% After CYD	40% After CYD
Urgent Care (Per Visit)	20% After CYD	40% After CYD
Hospital Services		
Inpatient Hospital (Per Admission)	20% After CYD	40% After CYD
Outpatient Hospital (Per Visit)	20% After CYD	40% After CYD
Physician Services at Hospital	20% After CYD	40% After CYD
Emergency Room (Per Visit)	0% After CYD	0% After In-Network CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services (Per Admission)	20% After CYD	40% After CYD
Outpatient Services (Per Visit)	20% After CYD	40% After CYD
Prescription Drugs (Rx)		
Tier 1	\$10 Retail Copay	\$10 Retail Copay
Tier 2	\$30 Retail Copay	\$30 Retail Copay
Tier 3	\$50 Retail Copay	\$50 Retail Copay
Mail Order Drug (90-Day Supply)	2x Retail Copay	Not Covered

Health Savings Account

The UnitedHealthcare High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollee to open a Health Savings Account (HSA). An HSA is an interest-bearing account where funds may be used to help pay employee and dependent(s) deductible, coinsurance and any qualified health care expenses not covered by the plan.

2021 Plan Year Funding:

- \$1,000
- \$41.67 Deposited Each Pay Period

Employee may opt to fund an HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction; this decision must be made during Open Enrollment. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free).

- **2020 IRS Contribution Limitations:**
\$3,550 (individual coverage) \$7,100 (Family Coverage)
- **2021 IRS Contribution Limitations:**
\$3,600 (individual coverage) \$7,200 (Family Coverage)

Guidelines regarding the HSAs are established by the IRS.

What to know about an HSA

- Employee owns the HSA funds from day one and decides how and when to spend the money.
- No use-it-or-lose-it rules; funds are in the account when needed, now or in the future. Participant cannot fund a traditional Health Care FSA.
- HSA funds earn interest.
- The HSA will be funded with employer contributions. If employee desires to fund the remaining IRS HSA Combined Contribution Limit balance, they may do so with pre-tax payroll deductions.
- HSA dollars may be used tax-free for all eligible health care expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employee plan for retirement.
- An account holder may write a check or withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.
- Account holder can access HSA statement at any time to track account balance and activity online at www.myuhc.com.

- To be eligible to open an HSA, employees must be covered by a high deductible health plan. Employee may not be covered under another medical plan that is not a high deductible health plan including a plan the employee's spouse may have selected where he/she has family coverage. Please Note: Eligibility status to qualify for an HSA is specifically driven by employee and NOT dependents.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Over-age dependent is not able to use HSA funds for qualified expenses, even if dependent is covered under the medical plan as Federal law does not recognize them as a qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits the Town from contributing HSA funds into the account. If employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts.
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare is eligible to enroll and contribute into the HSA up to the maximum contribution amounts. These funds can be utilized for the active employee and spouse expenses.
- Active employee ON Medicare and with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse may not contribute or receive HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

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

UnitedHealthcare | Customer Service: (800) 357-0978 | www.myuhc.com



Dental Insurance

Humana DHMO HS205 Plan

The Town offers dental insurance through Humana 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 Humana's customer service.

Dental Insurance – Humana DHMO HS205 Plan

24 Payroll Deductions - Per Pay Period Premium

Tier of Coverage	Employee Cost
Employee Only	Please see page 26 for plan cost and benefit choice dollars allowance.
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	

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 Humana DHMO 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.
- Prior authorization is not required for specialty referrals for Endodontic, Orthodontic and Pediatric Services.
- Waiting periods and age limitations may apply.

Humana | Customer Service: (800) 233-4013 | www.humanadental.com



Humana DHMO HS205 Plan At-A-Glance

Network	DHMO	
Calendar Year Deductible (CYD)	In-Network	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Calendar Year Benefit Maximum	In-Network	
Per Member	Does Not Apply	
Class I Services: Diagnostic & Preventive Care*	Code	In-Network
Routine Oral Exam (2 Per Year)	0120	\$0
Routine Cleanings (2 Per Year)	1110	\$0
Complete X-rays (1 Every 3 Years)	0210	\$0
Bitewing X-rays (2 Per Year)	0274	\$0
Class II Services: Basic Restorative Care*		
Fillings (Amalgam)	2160	\$5 Copay
Fillings (Resin, 3 Surface Posterior)	2393	\$80 Copay
Simple Extractions (Erupted Tooth or Exposed Root)	7210	\$40 Copay
Root Canal Therapy (Molar)*	3330	\$250 Copay
Surgical Removal of Tooth (Impacted)	7240	\$85 Copay
Full Mouth Debridement (1 Every 5 Years)	4355	\$50 Copay
Class III Services: Major Restorative Care*		
Crowns (Porcelain Fused to Metal)	2750	\$270 Copay
Bridges (Porcelain Fused to Metal)	6240	\$270 Copay
Dentures (Upper or Lower)	5110/20	\$375 Copay
Class IV Services: Orthodontia		
Benefit - Child/Adult	8070/8090	\$1,900 Copay
Evaluation	8070/8090	\$45 Copay
Treatment Planning/Records	8070/8090	\$250 Copay
Retention	8680	\$455 Copay



Locate a Provider

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



Plan References

* Excluding final restoration



Dental Insurance

Humana DHMO Advantage Plus Plan

The Town offers dental insurance through Humana 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 Humana's customer service.

Dental Insurance – Humana DHMO Advantage Plus Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	Please see page 26 for plan cost and benefit choice dollars allowance.
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	

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 Humana Advantage 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.
- Prior authorization is not required for specialty referrals for Endodontic, Orthodontic and Pediatric Services.
- Waiting periods and age limitations may apply.

Humana | Customer Service: (800) 979-4760 | www.humana.com



Humana DHMO Advantage Plus Plan At-A-Glance

Network		Advantage Plus	
Calendar Year Deductible (CYD)		In-Network	
Per Member		Does Not Apply	
Per Family			
Waived for Class I Services?			
Calendar Year Benefit Maximum		Does Not Apply	
Per Member			
Class I Services: Diagnostic & Preventive Care	Code	In-Network	
Office Visit	N/A	\$5/\$15 Copay	
Routine Oral Exam (2 Per Year)	0120	\$0 Copay	
Routine Cleanings (2 Per Year)	1110	\$0 Copay	
Complete X-rays (1 Every 3 Years)	0210	\$0 Copay	
Bitewing X-rays (2 Per Year)	0274	\$0 Copay	
Class II Services: Basic Restorative Care*			
Fillings (Amalgam)	2160	\$37 Copay	
Fillings (Resin, 3 Surface Posterior)	2393	\$46 Copay	
Simple Extractions (Erupted Tooth or Exposed Root)	7210	\$43 Copay	
Root Canal Therapy (Molar)*	3330	\$199 Copay	
Surgical Removal of Tooth (Impacted)	7240	\$84 Copay	
Full Mouth Debridement (1 Every 5 years)	4355	\$26 Copay	
Class III Services: Major Restorative Care*			
Crowns (Porcelain Fused to Metal)	2750	\$466 Copay	
Bridges (Porcelain Fused to Metal)	6240	\$426 Copay	
Dentures (Upper or Lower)	5110/20	\$642 Copay	
Class IV Services: Orthodontia			
Benefit - Child/Adult	8070/8090	\$2,100 Copay/\$2,300 Copay	
Treatment Planning/Records	8070/8080/8090	\$250 Copay	
Retention	8680	\$450 Copay	



Locate a Provider

To search for a participating provider, contact Humana's customer service or visit www.humana.com. When completing the necessary search criteria, select Advantage Plus network.



Plan References

* Excluding final restoration



Dental Insurance

Humana DPPO Low Plan

The Town offers dental insurance through Humana to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and 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 Humana's customer service.

Dental Insurance – Humana DPPO Low Plan

24 Payroll Deductions - Per Pay Period Premium

Tier of Coverage	Employee Cost
Employee Only	Please see page 26 for plan cost and benefit choice dollars allowance.
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	

In-Network Benefits

The DPPO Low 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 Humana PPO/Traditional Preferred network. These participating dental providers have contractually agreed to accept Humana's contracted fee or "allowed amount." This fee is the maximum amount a Humana dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

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

Calendar Year Deductible

The DPPO Low 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 DPPO Low plan will pay for each covered member is \$1,000 for in-network and out-of-network services combined. All services, including preventive services, 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.

Humana | Customer Service: (800) 233-4013 | www.humana.com



Humana DPPPO Low Plan At-A-Glance

Network	PPO/Traditional Preferred	
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)		
Routine Cleanings (2 Per Year)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)
Complete X-rays (1 Every 5 Years)		
Bitewing X-rays (1 Set 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		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD (Subject to Balance Billing)
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum		\$1,000
Benefit (Dependent Children Age 18 and Under)	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)



Locate a Provider

To search for a participating provider, contact Humana's customer service or visit www.humana.com. When completing the necessary search criteria, select PPO/Traditional Preferred 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 \$300 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.
- Waiting periods and age limitations may apply.
- Benefit frequency limitations may apply to certain services.



Dental Insurance

Humana DPPO High Plan

The Town offers dental insurance through Humana to benefit-eligible employees. A brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Humana's customer service.

Dental Insurance – Humana DPPO High Plan 24 Payroll Deductions - Per Pay Period Premium

Tier of Coverage	Employee Cost
Employee Only	Please see page 26 for plan cost and benefit choice dollars allowance.
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	

In-Network Benefits

The DPPO High 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 Humana PPO/Traditional Preferred network. These participating dental providers have contractually agreed to accept Humana's contracted fee or "allowed amount." This fee is the maximum amount a Humana dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

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

Calendar Year Deductible

The DPPO High 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 DPPO High plan will pay for each covered member is \$2,000 for in-network and out-of-network services combined. All services, including preventive services, 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.

Humana | Customer Service: (800) 233-4013 | www.humana.com



Humana DPPO High Plan At-A-Glance

Network	PPO/Traditional Preferred	
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		\$2,000
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam (2 Per Year)		
Routine Cleanings (2 Per Year)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)
Complete X-rays (1 Every 5 Years)		
Bitewing X-rays (1 Set 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		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD (Subject to Balance Billing)
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum		\$1,000
Benefit (Dependent Children Age 18 and Under)	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)



Locate a Provider

To search for a participating provider, contact Humana's customer service or visit www.humana.com. When completing the necessary search criteria, select PPO/Traditional Preferred 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 \$300 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.
- Waiting periods and age limitations may apply.
- Benefit frequency limitations may apply to certain services.



Vision Insurance

Humana Vision 130 Plan

The Town offers vision insurance through Humana 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 Humana's customer service.

Vision Insurance - Humana Vision 130 Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	Please see page 26 for plan cost and benefit choice dollars allowance.
Employee + Family	

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 Humana 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 Humana Insight network. When going out of network, the provider will require payment at the time of appointment. Humana 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.

Humana

Customer Service: (800) 233-4013 | www.humana.com



Humana Vision 130 Plan At-A-Glance

Network		Insight	
Services		In-Network	Out-of-Network
Eye Exam		\$10 Copay	Up to \$30 Allowance
Contact Lens Exam		Standard - \$55 Allowance Premium - 10% Off Retail	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		\$15 Copay	Up to \$25 Reimbursement
Bifocal		\$15 Copay	Up to \$40 Reimbursement
Trifocal		\$15 Copay	Up to \$60 Reimbursement
Frames			
Allowance		\$130 Allowance 20% Off Over \$130 Allowance	\$65 Retail Allowance
Contact Lenses*			
Non-Elective (Medically Necessary)		Covered at 100%	\$200 Allowance
Elective (Fitting, Follow-up & Lenses)	Conventional	\$130 Allowance 15% Off Over \$130 Allowance	\$104 Allowance
	Disposable	\$130 Allowance	\$104 Allowance



Locate a Provider

To search for a participating provider, contact Humana's customer service or visit www.humana.com. When completing the necessary search option, 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 Town offers Flexible Spending Accounts (FSA) administered through WageWorks. The FSA plan year is from January 1 to December 31.

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 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

- 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 and/or grace period.
- 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 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. WageWorks 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 Town. 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 \$41.67 based on a 24 pay period schedule. As a result, the 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."**

WageWorks | Phone: (800) 950-0105 | Claims Fax: (877) 782-8889
www.takecarewageworks.com



Employee Assistance Program

The Town 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 Care24 with UnitedHealthcare. 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 telephonic consultation and online material/tools. 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), 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. The referring supervisor will not receive specific information regarding the referred employee's case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Care24

UnitedHealthcare | Customer Service: (888) 887-4114 | www.myuhc.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The Town provides Basic Term Life insurance for all eligible employees, at no cost, through The Standard. Eligible employees will receive a benefit amount of:

- > Class 1 (Police) - \$100,000
- > Class 2 - \$50,000

Accidental Death & Dismemberment Insurance

Also, at no cost to the employee, The Town 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 50% of the benefit amount at age 70

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

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



Voluntary Life Insurance

Voluntary Employee Life Insurance

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

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

- Units can be purchased in increments of \$10,000 to the maximum of \$400,000.
- Benefit amounts are subject to the following age reduction schedule:
 - › Reduces to 50% of the benefit amount at age 70

Voluntary Spouse Life Insurance

- Employee must participate in the Voluntary Employee Life plan for spouse to participate.
- Employee may purchase coverage in the amount of \$10,000.
- Cost for Voluntary Spouse Life coverage is \$1.27 semi-monthly.
- Benefit amounts are subject to the following age reduction schedule:
 - › Reduces to 50% of the benefit amount at age 70

Voluntary Employee Life Insurance Rate Table

Monthly Premium

Age Bracket <i>(Based on Employee Age)</i>	Employee <i>(Rate Per \$1,000 of Benefit)</i>
< 30	\$0.088
30-34	\$0.096
35-39	\$0.104
40-44	\$0.144
45-49	\$0.224
50-54	\$0.336
55-59	\$0.504
60-64	\$0.768
65-69	\$1.344
> 69	\$2.168

Voluntary Dependent Child(ren) Life Insurance

- Employee must participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- Employee may purchase coverage in the amount of \$10,000.
- Cost for Voluntary Dependent Child Life is \$1.00 semi-monthly, for all children, birth through age 20 (age 24 if full-time student)

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

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



Short Term Disability

The Town provides Short Term Disability (STD) insurance to all eligible employees through The Standard. The STD benefit pays employee a percentage of the weekly earnings if employee becomes disabled due to an illness or non-work related injury.

Short Term Disability (STD) Benefits

- STD provides a benefit of 50% of employee's weekly earnings up to a benefit maximum of \$1,500 per week.
- Employee must be disabled for 20 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 21st day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 90 days.
- Employee deemed unable to return to work after the STD 90 day maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefits may be reduced by other income.
- Disability benefits are taxable.

The Standard | Customer Service: (800) 368-2859 | www.standard.com

Long Term Disability

The Town offers Basic and Buy-Up Long Term Disability (LTD) insurance to all eligible employees through The Standard. 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 50% of employee's monthly earnings up to a benefit maximum of \$7,500 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 maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.

Optional Buy-Up Long Term Disability

Employees have the option to purchase additional LTD benefits for a premium.

- LTD provides a benefit of 60% of employees monthly earnings up to a benefit maximum of \$7,500 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 maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.
- Premium Calculation:
 $\text{Monthly Earnings} \times \$0.18 \div 100 = \text{Estimated Monthly Premium}$

The Standard | Customer Service: (800) 368-1135 | www.standard.com



Supplemental Insurance

Aflac

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

- ✓ Cancer Protection (*Option 1 or 2*)
- ✓ Accident Off the Job
- ✓ Hospital Choice Confinement Indemnity

To learn more about these Aflac plans and/or to schedule a personal appointment, contact the Town's Aflac Agent.

Aflac | Customer Service: (800) 992-3522 | www.aflac.com
 Agent: Gene Villa | Phone: (561) 714-4224 | Email: gene@definovilla.com

Colonial Life

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

- ✓ Accident On & Off the Job
- ✓ Whole Life (*Up to \$50,000 GI*)
- ✓ Critical Illness (*Up to \$20,000 GI*)
- ✓ Term Life Insurance (*10, 15, 20, or 30 Year Term*)

Colonial Life | Customer Service: (800) 325-4368 | www.coloniallife.com
 Agent: Donna Tilton | Phone: (954) 829-4930
 Email: Donnal.Tilton@coloniallifesales.com
 Agent: Gene Villa | Phone: (561) 714-4224
 Email: gene@definovilla.com

Pet Insurance

Nationwide

The Town offers employees the opportunity to purchase pet insurance on a voluntary basis through Nationwide. Participating members receive up to 90% reimbursement from Nationwide on vet bills. Participating providers cover medical treatments and surgeries for accidents, illnesses, and medical conditions. Also, included at no additional cost is Nationwide's 24/7/365 vet helpline that helps pet owners with any pet questions. Members can sign up multiple pets with individual plans and receive a discount for even more savings. See policy document for a complete list of exclusions.

Nationwide: Enrollment Options

1. Go directly to: www.petinsurance.com/affiliates/davieflgov; or
2. Visit petsnationwide.com and enter your company name; or
3. Call (877) 738-7874 and mention you are an employee of the Town of Davie

Pet Insurance – Nationwide

	My Pet Protection with Wellness	My Pet Protection
Common Illnesses	✓	✓
Surgeries & Hospitalization	✓	✓
X-rays, MRIs and CT Scans	✓	✓
Prescription Medications	✓	✓
Wellness Exams	✓	
Preventive Dental Cleaning	✓	
Spay/Neuter	✓	
Routine Blood Tests	✓	
Heartworm Testing & Prevention	✓	

Nationwide | Customer Service: (877) 738-7874
www.petinsurance.com/affiliates/davieflgov



Legal Plan and Identity Theft

LegalShield - IDShield

The Town offers employees the opportunity to participate in a voluntary legal and/or identity theft plan(s) through LegalShield. By enrolling in the legal plan, participant and family have direct access to highly rated nationwide law firms. These firms will be able to assist with unlimited numbers of personal or business legal situations including pre-existing conditions. LegalShield benefit plans are portable, rate stable and include all matters from the trivial to the traumatic. But not limited to the following benefits:

- ✓ Covid-19 Resource Assistance
- ✓ Family Law Matters
- ✓ Landlord & Tenant Issues
- ✓ Estate Planning & Wills
- ✓ Auto Violations or Accidents
- ✓ Consumer Financial Concerns
- ✓ Real Estate
- ✓ Contract Review

The Town also offers employees the opportunity to participate in an identity theft plan through IDShield, which protects participant spouse, significant other and up to 10 dependent children up to age 26. IDShield offers unlimited consults with Licensed Private Investigators who are Certified Fraud Examiners with 24/7 emergency access. Additional plan features are added each year at no additional cost. Pre-existing ID Theft matters are covered only as a group IDShield plan member, through the Town of Davie.

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

LegalShield - IDShield
24 Payroll Deductions - Per Pay Period Cost

Type of Coverage	Employee Cost
Legal Plan (Individual/Family)	\$7.98
Identity Theft Protection Plan (Family)	\$6.98
Identity Theft Protection Plan (Individual)	\$6.48
Legal Plan & Identity Theft Protection Plan (Individual/Family)	\$12.95

LegalShield | www.legalshield.com/info/townofdavie
Agent: Yvette Mayo | Cell Phone: (407) 719-4897
Email: mayogroupbenefits@msn.com

U.S. Legal

By enrolling in this plan, participants will have direct access to attorneys who will provide services for a variety of issues that include, but are not limited to:

- ✓ Divorce
- ✓ Child Custody & Support
- ✓ Domestic Adoption
- ✓ Consumer Law
- ✓ Bankruptcy
- ✓ Foreclosure Assistance
- ✓ Criminal Law
- ✓ Real Estate
- ✓ Traffic Tickets, DUI
- ✓ Debt Collection Defense
- ✓ Estate Planning
- ✓ Wills & Trusts

The optional Identity Defender program assists at the inception of a fraud-related emergency, helps restore identity and good credit, helps with ID theft, and educates on preventive steps to protect identity.

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

Legal & Identity Theft Plan - U.S. Legal
24 Payroll Deductions - Per Pay Period Cost

Type of Coverage	Employee Cost
Legal Only	\$9.38
Identity Defender Only	\$4.98
Legal and Identity Defender	\$11.35

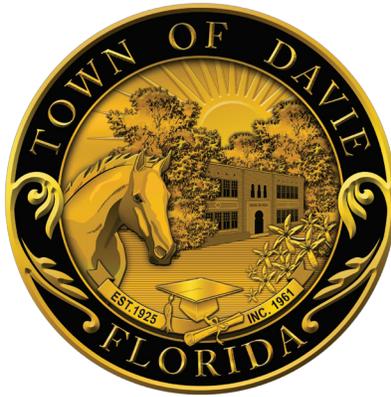
U.S. Legal | www.uslegalservices.net
Agent: Dixie Kuehn | Phone: (321) 403-0156 | Email: dixiekuehn@clf.rr.com



Notes

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

A series of horizontal dotted lines providing a space for handwritten notes.



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