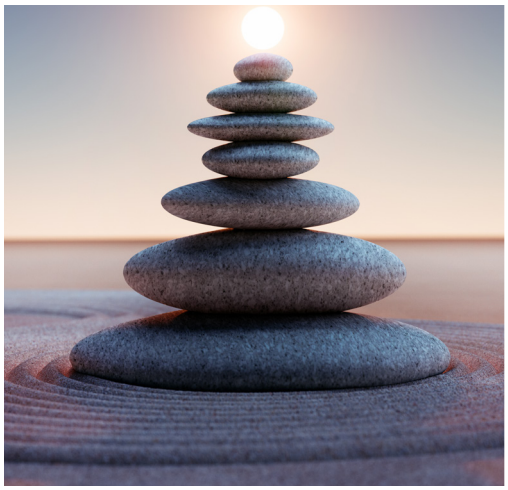
Palm Beach

2023 EMPLOYEE BENEFIT HIGHLIGHTS



Contact Information

	People and Culture Department		Phone: (561) 838-5450 Option 2
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) Email: support@mybentek.com www.mybentek.com/townofpalmbeach
	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	National Vision Administrators (NVA)	Customer Service: (800) 672-7723 www.e-nva.com Group Number: 51193000001
	Flexible Spending Accounts	Flores	Customer Service: (800) 532-3327 www.flores247.com
	Employee Assistance Program	Cigna	Customer Service: (877) 622-4327 www.mycigna.com
	Basic Life and AD&D Insurance	The Hartford	Customer Service: (800) 523-2233 www.thehartford.com
	Voluntary Life Insurance	The Hartford	Customer Service: (800) 523-2233 www.thehartford.com
	Voluntary Short Term Disability Insurance	Prudential	Customer Service: (800) 842-1718 www.prudential.com
	Long Term Disability Insurance	Prudential	Customer Service: (800) 842-1718 www.prudential.com
	Prepaid College	Florida Prepaid	Customer Service: (800) 552-4723 www.myfloridaprepaid.com

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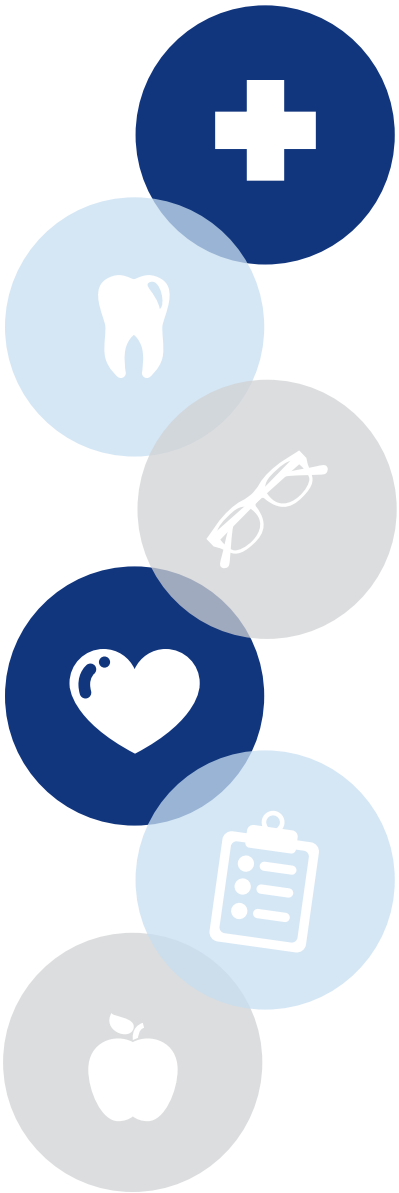


This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The Town of Palm Beach reserves the right to amend, modify or terminate the plan at any time. This booklet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

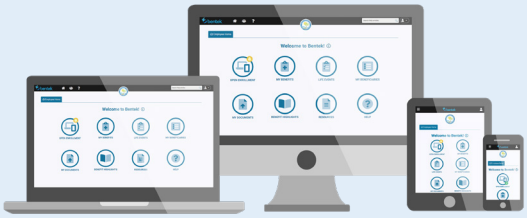
Introduction

The Town of Palm Beach 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 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 People and Culture 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/townofpalmbeach**
  Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com, Monday through Friday during regular business hours 8:30am - 5:00pm.

To access Bentek using a mobile device, scan code.

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 for medical, dental and vision will continue through the end of the pay period in which separation occurred. Other coverage may terminate on the last date of employment. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse/domestic partner 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/domestic partner

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

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

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

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 (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group's insurance plans; and
- The dependent has been continuously insured.

Proof of disability will be required upon request. Please contact the People and Culture Department if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under employee's medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, imputed income must be reported on the employee's W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare taxes. Imputed income is the dollar value of insurance coverage attributable to covering each adult dependent child. Contact the People and Culture 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 partner benefits are extended to either same or opposite-sex domestic partners of Town employees. All employees seeking domestic partner benefit coverage must complete and submit the Town's Affidavit of Domestic Partnership to the People and Culture Department prior to receipt of the designated benefits. In addition to the affidavit, employees who reside within Palm Beach County must register their domestic partnership with the Palm Beach County Clerk and Comptroller's office and provide proof of registration to the People and Culture Department. Employees who reside outside of Palm Beach County must complete the Town's Declaration of Domestic Partnership form. All forms, including a link to the Palm Beach County Clerk and Comptroller's office can be found on the Employee and Supervisor Forms page of the Town's Intranet.

Per IRS rules, an employee may not receive a tax advantage on any portion of premium attributable to a domestic partnership. Imputed income for the value applicable to the domestic partner coverage for the period of coverage, including the value of the coverage for a domestic partner's child(ren), must be reported on the employee's W-2 and taxed accordingly. Imputed income is the dollar value of insurance coverage attributable to covering the domestic partner (and the domestic partner's child(ren).

Domestic Partners Who Become Married: Opposite or Same Sex Domestic Partners (IRS Revenue Ruling 2013-17) who legally marry must submit a Life Event in Bentek within 30 days of the marriage and provide supporting documentation.

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 People and Culture 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.

Wellness Program

Full-time and regular part-time employees and spouses enrolled in the Town's medical insurance plan are eligible to participate in the Wellness Program. Employee participation in the program is optional and voluntary for employees; however, those who complete the wellness activities will receive reduced premiums in the Town's plans. Participation for spouses is optional and voluntary and will not affect the premium employees pay.

Activities for the 2023 insurance plan year include: (1) a Biometric Screening; (2) an online Health Risk Assessment (HRA); and (3) a Tobacco-Free Affidavit or submission of certificate of completion from the Town sponsored tobacco cessation program or equivalent program.

Biometric Screening

The biometric screening test will consist of the following:

- ✓ Blood Glucose
- ✓ Total Cholesterol
- ✓ Triglycerides
- ✓ Blood Pressure
- ✓ HDL Cholesterol
- ✓ Body Mass Index
- ✓ Cholesterol Ratio

Online Health Risk Assessment

Once employee receives the biometric screening results, employee will be asked to enter biometric and tobacco screening results and provide answers to a series of questions about health and lifestyle choices. This information will be translated into a detailed personal wellness report. Employee will have the option to print the report that includes the overall wellness score and pertinent information about health risks, lifestyle choices, and risk reduction strategies.

Tobacco Free Wellness Activities

2023 Tobacco Free – Employee must complete one (1) of the following:

- Sign the non-tobacco user affidavit

  OR
- Submit a certificate of completion of the Town's sponsored tobacco cessation program (or equivalent).

Confidentiality

Once the health screenings are completed, the carrier will compile the results and provide the Town with an executive summary in an aggregate report that will include a breakdown of group results in eleven areas of health status and overall wellness. The Town will use this data to develop lunch and learns and wellness programs that will be beneficial to all employees town wide. Employee data will be gathered and stored by Quest Diagnostics or LabCorp and the carrier with absolute dedication to privacy and confidentiality in accordance with HIPAA regulations. No individual data will ever be shared with anyone in the Town.

Medical Insurance

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

Medical Insurance
Cigna Open Access Plus In-Network Only - Seaview Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost With Completed Wellness	Employee Cost Without Completed Wellness
Employee Only	$0.00	$27.80
Employee + 1 Dependent	$61.68	$120.27
Employee + 2 Dependents	$123.36	$212.73
Employee + 3 or More Dependents	$185.04	$305.19

Medical Insurance
Cigna Open Access Plus - Seabreeze Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost With Completed Wellness	Employee Cost Without Completed Wellness
Employee Only	$52.72	$86.85
Employee + 1 Dependent	$173.35	$245.34
Employee + 2 Dependents	$294.00	$403.85
Employee + 3 or More Dependents	$414.63	$562.33

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

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:	People and Culture Department
Address:	360 S. County Rd. Palm Beach, FL 33480
Phone:	(561) 838-5450, Option 2
Website URL:	www.mybentek.com/townofpalmbeach

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 People and Culture Department.

If there are any questions about the plan offerings or coverage options, please contact the People and Culture Department at (561) 838-5450, Option 2.

Opt-Out Benefits

Employees with other medical coverage, either through their spouse or through a previous employer, may be eligible to receive an incentive payment of $175 per month. In order to receive the incentive, employee must opt out of the Town's medical insurance coverage.

If employee wishes to opt out of the Town's medical insurance plan, reasonable evidence of alternative coverage for the 2023 plan year must be provided. This can be a health insurance card or a letter of creditable coverage from your carrier. Proof of medical insurance coverage along with the Medical Insurance Opt-Out form must be submitted to the People and Culture Department. The Medical Insurance Opt-Out Form can be found on the Town's Intranet under Employee Benefits Information. Incentive payments are paid monthly on the first paycheck of the month.

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.

24-Hour Help Information Hotline (800) CIGNA-24

The Cigna 24-Hour Health Information Line provides access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do for a child who has a fever in the middle of the night? Not sure if treatment from a doctor is necessary for an injury? There are over 1,000 topics in the Health Information Library to help weigh the risks and advantages of treatment options. The call is free and is strictly confidential.

Healthy Rewards

Cigna's Healthy Rewards is provided automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can register on www.mycigna.com and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- ✓ Vision Care
- ✓ Lasik Vision Correction Services
- ✓ Fitness Club Discounts
- ✓ Nutrition Discounts
- ✓ Hearing Care

The myCigna Mobile App

The myCigna mobile app is an easy way to organize and access important health information. Anytime. Anywhere. Download it today from the App Store℠ or Google Play™. With the myCigna mobile app, members can:

- ✓ Find a doctor, dentist or health care facility
- ✓ Access maps for instant driving directions
- ✓ View ID cards for the entire family
- ✓ Review deductibles, account balances and claims
- ✓ Compare prescription drug costs
- ✓ Speed-dial Cigna Home Delivery Pharmacy™
- ✓ Add health care professionals to contact list right from a claim or directory search

Prescription Drugs - Cigna 90 Now

Employees taking maintenance medications which are prescribed for chronic long-term conditions and are taken on a regular recurring basis, must now fill these prescriptions at a Cigna 90 Now pharmacy or through Cigna Home Delivery. Employees may choose a different pharmacy, but the prescription will not be covered by the Town's sponsored insurance. To find a Cigna 90 Now pharmacy, log on to 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 required and should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telehealth, such as:

- ✓ Sore Throat
- ✓ 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..

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

Cigna Open Access Plus In-Network Only Seaview Plan At-A-Glance

Locate a Provider

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

Plan References

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

***Pharmacy Deductible: The plan has a separate calendar year pharmacy deductible of $100 per member. This deductible applies only to brand name prescriptions.*

Important Notes

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

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	Does Not Apply
Family	Does Not Apply
Coinsurance	
Member Responsibility	Does Not Apply
Calendar Year Out-of-Pocket Limit	
Single	$1,500
Family	$3,000
What Applies to the Out-of-Pocket Limit?	Copays
Physician Services	
Primary Care Physician *(PCP)* Office Visit / Virtual Care *(PCP Election Required)*	$20 Copay
Specialist Office Visit / Virtual Care *(No Referral Required)*	$40 Copay
Telehealth Services	No Charge
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)**	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	No Charge
Outpatient Surgery in Surgical Center	$100 Copay
Physician Services at Surgical Center	No Charge
Urgent Care *(Per Visit)*	$30 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	$500 Copay
Outpatient Hospital *(Per Visit)*	$100 Copay
Physician Services at Hospital	No Charge
Emergency Room *(Per Visit; Waived if Admitted)*	$115 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	$500 Copay
Outpatient Services *(Per Visit)*	No Charge
Outpatient Office Visit	$40 Copay
Prescription Drugs *(Rx)*	
Pharmacy Deductible**	$100 Individual / $200 Family
Pharmacy Out-of-Pocket Limit	$5,100 Individual / $8,700 Family
Generic	$10 Copay
Preferred Brand Name	$30 Copay After CYD
Non-Preferred Brand Name	50% After CYD
Mail Order Drug *(90-Day Supply)*	2x Retail Copay

Cigna Open Access Plus Seabreeze Plan At-A-Glance

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$500	$1,000
Family	$1,500	$3,000
Coinsurance		
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Limit		
Single	$1,500	$3,000
Family	$4,500	$9,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance and Copays	
Physician Services		
Primary Care Physician *(PCP)* Office Visit / Virtual Care	$25 Copay	30% After CYD
Specialist Office Visit / Virtual Care	$40 Copay	30% After CYD
Telehealth Services	No Charge	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	10% Coinsurance	30% After CYD
X-rays	10% Coinsurance	30% After CYD
Advanced Imaging *(MRI, PET, CT)*	10% Coinsurance	30% After CYD
Outpatient Surgery in Surgical Center	10% After CYD	30% After CYD
Physician Services at Surgical Center	10% After CYD	30% After CYD
Urgent Care *(Per Visit)*	$30 Copay	$30 Copay
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After CYD	$300 PAD*** + 30% After CYD
Outpatient Hospital *(Per Visit)*	10% After CYD	30% After CYD
Physician Services at Hospital	10% After CYD	10% After CYD
Emergency Room *(Per Visit)*	10% After CYD	10% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After CYD	$300 PAD*** + 30% After CYD
Outpatient Services *(Per Visit)*	10% Coinsurance	30% After CYD
Outpatient Office Visit	$40 Copay	30% After CYD
Prescription Drugs *(Rx)*		
Pharmacy Deductible****	$100 Individual / $200 Family	Not Covered
Pharmacy Out-of-Pocket Limit	$5,100 Individual / $8,700 Family	
Generic	$10 Copay	
Preferred Brand Name	$30 Copay After CYD	
Non-Preferred Brand Name	50% After CYD	
Mail Order Drug *(90-Day Supply)*	2x Retail Copay	

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Open Access Plus, OA Plus, Choice Fund OA 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 Cigna. When using a lab other than LabCorp or Quest Diagnostics, please confirm they are contracted with Cigna Open Access Plus network prior to receiving services.*

****PAD: Per Admission Deductible*

*****Pharmacy Deductible: The plan has a separate calendar year pharmacy deductible of $100 per member. This deductible applies only to brand name prescriptions*

Dental Insurance

Cigna Total DPPO Plan

The Town 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 Total DPPO Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee +1 Dependent	$16.88
Employee + 2 or More Dependents	$27.87

In-Network Benefits

The Cigna Total DPPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Total Cigna DPPO network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

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

Out-of-Network Benefits

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

Calendar Year Deductible

The Cigna Total DPPO 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 Cigna Total DPPO plan will pay for each covered member is $2,000 for in-network and out-of-network services combined. All services, including preventive, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

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

Cigna Total DPPO Plan At-A-Glance

Network	Total Cigna DPPO	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
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 Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 90% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Calendar Year)*		
Complete X-rays *(1 Per 36 Months)*		
Bitewing X-rays *(2 Per Calendar Year)*		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% After CYD	Plan Pays: 60% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Oral Surgery		
Periodontal Services		
Endodontics *(Root Canal Therapy)*		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 40% After CYD *(Subject to Balance Billing)*
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 (Cigna DPPO Advantage and Cigna DPPO) network.

Plan References

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

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.*

Vision Insurance

National Vision Administrators Vision Plan

The Town offers vision insurance through National Vision Administrators (NVA) 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 NVA's customer service.

Vision Insurance - NVA Vision Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$2.83
Employee + Spouse	$5.10
Employee + Child(ren)	$5.39
Employee + Family	$7.38

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 NVA 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 costs 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 NVA network. When going out of network, the provider will require payment at the time of appointment. NVA 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.

National Vision Administrators
Customer Service: (800) 672-7723 | www.e-nva.com
Group Number: 51193000001

National Vision Administrators Vision Plan At-A-Glance

Network		NVA	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 Copay	Up to $30 Reimbursement
Contact Lens Exam *(Fit & Follow-up)*	Standard Daily Wear	No Charge	Up to $20 Reimbursement
	Standard Extended Wear	No Charge	Up to $30 Reimbursement
	Specialty	$20 Copay	Up to $30 Reimbursement
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 $35 Reimbursement
Trifocal		$15 Copay	Up to $45 Reimbursement
Frames			
Allowance		$150 Allowance; Then 20% Discount Off Balance	Up to $40 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $200 Reimbursement
Elective *(Lenses)*	Conventional	$150 Allowance; Then 15% Discount Off Balance	Up to $120 Reimbursement
	Disposable	$150 Allowance; Then 10% Discount Off Balance	Up to $120 Reimbursement

Locate a Provider

To search for a participating provider, contact National Vision Administrator's customer service or visit www.e-nva.com. When completing the necessary search criteria, select the Town's group number: 51193000001.

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 Flores. 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 $2,850. 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 and/or grace period.
- 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, New Hire Orientation or for Qualifying Life Events.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail, fax, email, or through the Flores Mobile App. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. Flores 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!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $38.46 based on a 26 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$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."***

Claims Mailing Address
Flores | P.O. Box 31397 Charlotte, NC 28231-1397 | Fax: (800) 726-9982

Flores | Phone: (800) 532-3327 | www.flores247.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 Cigna. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

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

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

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or the People and Culture Department), 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.

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

Basic Life and AD&D Insurance

Basic Term Life Insurance

The Town provides Basic Term Life insurance at no cost to all eligible employees through The Hartford. Eligible employees will receive a benefit amount equal to one (1) year annual earnings rounded to the next highest one thousand dollars, with a maximum of $100,000.

Upon the death of employee, if the Total Basic Life insurance payment is less than $100,000, the Town will supplement the difference between the Basic Life insurance amount paid and $100,000, to assure a total Life insurance payment of $100,000 to every employee's beneficiary.

Accidental Death & Dismemberment Insurance

Also, at no cost to 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 65% of the benefit amount at age 70
- › Reduces to 45% of the benefit amount at age 75
- › Reduces to 30% of the benefit amount at age 80

Life Insurance Imputed Income

The IRS requires the imputed cost of employer paid Employee Basic Term Life insurance benefit in excess of $50,000 must be included as income and is subject to Federal, Social Security and Medicare taxes.

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

The Hartford | Customer Service: (800) 523-2233 | www.thehartford.com

Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible employee may elect to purchase additional Life insurance on a voluntary basis through The Hartford. This coverage may be purchased in addition to the Basic Term Life and AD&D 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 $300,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 70
  - Reduces to 45% of the benefit amount at age 75
  - Reduces to 30% of the benefit amount at age 80

Voluntary Spouse Life 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 $25,000.**

- Employee must participate in the Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $5,000 to a maximum of $150,000 not to exceed 100% of the employee's Voluntary Life coverage amount.
- Benefit amounts are subject to the following age reduction schedule based on employee's age:
  - Reduces to 65% of the benefit amount at age 70
  - Reduces to 45% of the benefit amount at age 75
  - Reduces to 30% of the benefit amount at age 80

Voluntary Life Insurance Rate Table

Monthly Premium

Age Bracket *(Based on Employee Age)*	Employee *(Rate Per $1,000 of Benefit)*	Spouse *(Rate Per $1,000 of Benefit)*
Under 25	$0.074	$0.047
25-29	$0.074	$0.056
30-34	$0.093	$0.065
35-39	$0.140	$0.093
40-44	$0.205	$0.112
45-49	$0.326	$0.158
50-54	$0.512	$0.260
55-59	$0.884	$0.409
60-64	$1.116	$0.679
65-69	$1.897	$1.135
70-74	$3.225	$1.135
75+	$5.487	$1.135

Voluntary Dependent Child(ren) Life Insurance

- Employee must participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- Employee may elect coverage in the amount of $10,000.
- Cost is $1.20 a month and covers all eligible children from live birth through age 24.
- Child(ren) age 14 days to 6 months receive a $1,000 benefit amount.

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

The Hartford | Customer Service: (800) 523-2233 | www.thehartford.com

Voluntary Short Term Disability

The Town offers Voluntary Short Term Disability (STD) insurance to all eligible employees through Prudential. The STD benefit pays employee a percentage of the weekly earnings if employee becomes disabled due to an illness or injury.

Voluntary Short Term Disability (STD) Benefits

- STD provides a benefit of 66.67% of employee's weekly earnings up to a benefit maximum of 1,000 per week.
- Employee must be disabled for 14 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 15th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 24 weeks.
- Employee deemed unable to return to work after the STD 24 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefits may be reduced by other income.
- Disability benefits may be taxable.

Voluntary Short Term Disability Rate Table

Monthly Premium

Age Bracket	Employee Cost *(Rate Per $10 of Benefit)*
<20	$0.40
20 – 24	$0.51
25 – 29	$0.55
30 – 34	$0.61
35 – 39	$0.44
40 – 44	$0.35
45 – 49	$0.38
50 – 54	$0.45
55 – 59	$0.55
60 – 64	$0.63
65 – 69	$0.55
70+	$0.90

Prudential | Customer Service: (800) 842-1718 | www.prudential.com

Long Term Disability

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

Employee LTD Plan Summary	
Definition of Disability	Disability means an employee cannot perform one or more of the essential duties of their occupation due to a non-work related injury, illness, pregnancy or other medical condition covered by the insurance, and as a result, current monthly earnings are 80% or less than the pre-disability earnings. Once disabled for 24 months following the elimination period, employee must be prevented from performing one or more of the essential duties of any occupation and as a result, their current monthly earnings are 60% less than pre-disability earnings.
Elimination Period	Benefit begins after 180 days.
Benefit Percent	The plan replaces up to 66.67% of basic monthly earnings.
Monthly Benefit Maximum	$4,000
Benefit Duration	If under age 61 when disabled, benefit may be payable up to the normal Social Security retirement at age 61 or older, benefit may be payable beyond normal retirement age. Consult the certificate for full description.
Pre-existing Condition	Any condition for which the medical attention was sought or medication was taken in the 180 days prior to coverage becoming effective will not be covered unless the date of the disability follows 365 days of continuous coverage under this plan.
Mental & Nervous / Substance Abuse	24 month limit unless confined to a facility.
Cost to Employees	None. The Town pays for this benefit.

Disability benefits may be taxable.

Prudential | Customer Service: (800) 842-1718 | www.prudential.com

Florida Prepaid College & 529 Savings Plans

The Town of Palm Beach has become a proud payroll partner of the Florida Prepaid College Board. Employees who currently have Florida Prepaid College plans or Florida 529 Savings Plans through the Florida Prepaid College Board can now elect to make payments through post-tax payroll deductions.

What is a Florida Prepaid College Plan?

A Florida Prepaid College Plan allows families to prepay, on a monthly or lump-sum basis, the future cost of college tuition, specified fees and dormitory housing. When a child is ready for college, the plan pays the tuition, tuition differential fee and other specified fees covered under the plan at any Florida College or State University. If a child attends an out-of-state college or private college, the plan will pay the same amount as it would pay at a public college or university in Florida. Every Prepaid Plan is guaranteed by the State of Florida.

What is a Florida 529 Savings Plan?

The Florida 529 Savings Plan offers flexibility in choosing from available investment options. Employee may then contribute as much and as often based on budget and goals. Each investment option is independently run by professional investment managers. The funds in 529 Savings Plans can be used for any qualified higher education expense, including tuition, room & board, textbooks, graduate school and much more. This gives extreme flexibility to use the funds as employee sees fit.

Payroll Deductions

Payroll deduction may be initiated only for existing or new Florida Prepaid College Plan accounts. Employee may visit the Florida Prepaid College Board website www.myfloridaprepaid.com for more information about the types of accounts available and applicable open enrollment periods to open new accounts.

Employees will need their Florida Prepaid College Plan 10-digit account number(s) to complete the payroll Deduction Authorization form, which can be found on the Florida Prepaid website or on the Town's Intranet under Employee Benefits Information. Employees must complete and submit the Payroll Deduction Authorization form to the People and Culture Department for processing.

Florida Prepaid | Customer Service: (800) 552-4723
www.myfloridaprepaid.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.

Notes

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GEHRING GROUP

A RISK STRATEGIES COMPANY

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