An aerial photograph of Marco Island, Florida, showing the city and surrounding waterways. The city is densely packed with buildings and is situated on a narrow strip of land. The surrounding water is a deep blue, and there are several smaller islands and peninsulas visible. The sky is a clear, light blue.

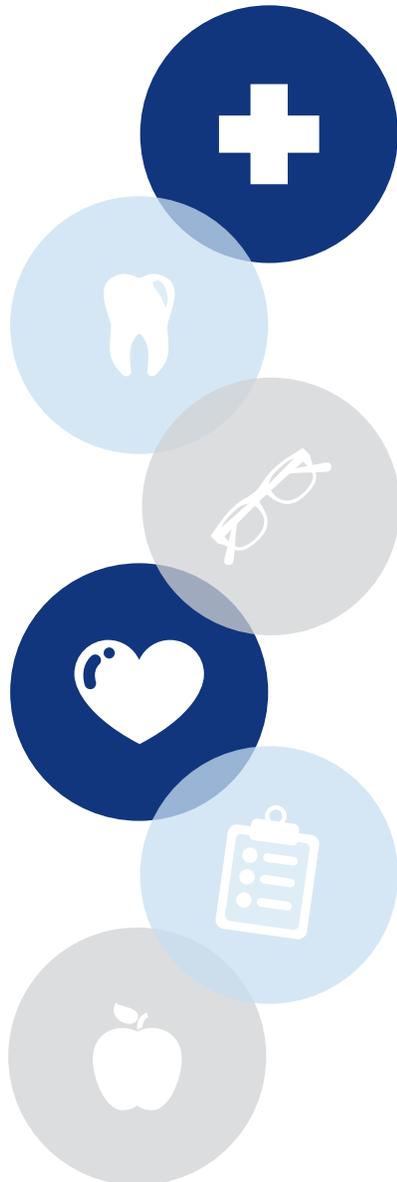
City of Marco Island

2016 | 2017 EMPLOYEE BENEFIT HIGHLIGHTS



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Contact Information

	Human Resources Administration	Leslie Sanford	Office: (239) 389-3970 Email: lsanford@cityofmarcoisland.com
	Claims, Billing & Benefit Assistance		Phone: (800) 244-3696 Email: marcoisland@gehringgroup.com
	Medical Insurance	United Healthcare	Customer Service: (800) 357-0978 www.myuhc.com
	Prescription Drug Coverage and Mail-Order Program	Optum Rx	Customer Service: (800) 788-4863 www.myuhc.com
	Dental Insurance	Delta Dental	Customer Service: (800) 521-2651 www.deltadentalins.com
	Vision Insurance	United Healthcare	Customer Service: (800) 638-3120 www.myuhcvision.com
	Flexible Spending Accounts	Paychex	Customer Service: (877) 244-1771 www.benefits.paychex.com
	Basic Life and AD&D Insurance	The Standard	Customer Service: (800) 348-3226 www.standard.com
	Additional Life Insurance	The Standard	Customer Service: (800) 348-3226 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	Employee Assistance Services	Customer Service: (239) 450-3255
	Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 www.aflac.com Local Agent: Anna Wiseman Phone: (239) 348-9944 Email: anna_wiseman@us.aflac.com



Introduction

The City of Marco Island offers group insurance coverage for all eligible employees. A variety of these plans have been highlighted in this booklet as a convenient reference. Please refer to the City's Personnel Policies and Procedures and group insurance Certificates of Coverage for detailed descriptions of all available employee benefit plans and stipulations therein. Questions and further clarifications regarding this booklet's contents may be directed to Human Resources.

Notice of Privacy Practice of The City of Marco Island

The City's Privacy Notice is available and you can obtain a copy by contacting Human Resources or on the website at www.cityofmarcoisland.com.

Please Note: More information is available on the above notices by contacting Human Resources.

Benefits Resource Center

The City provides an online benefit website through the Benefits Resource Center (BRC). The BRC provides benefit-eligible employees the ability to view group insurance benefit information online.



To access the Benefits Resource Center:

- ✓ Log on to www.mybentek.com/cityofmarcoisland
- ✓ Sign in by using your username and password

User Name: marcoisland.brc@mybentek.com

Password: [benefits123](#)

Accessible 24 hours a day, you can log on to the BRC at any time to view of the following:

- ✓ Employee Benefit Highlights Booklet
- ✓ Benefit Summaries
- ✓ Benefit Forms
- ✓ Important Contact Information
- ✓ Compliance & Notifications
- ✓ Direct Links to Carrier Websites

For technical issues directly related to using the BRC please call (888) 5-BenTek (523-6835) or email BenTek Support at support@mybentek.com, Monday through Friday, during regular business hours.

To access your group insurance benefits online, log on to www.mybentek.com/cityofmarcoisland

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



Group Insurance Eligibility



The City's group insurance plan year is November 1 through October 31

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are benefit eligible employees working a minimum of 30 hours per week.

Coverage will be effective the first of the month following an employee's date of hire. For example, if an employee is hired on May 11, then the effective date of coverage will be June 1.

Termination

If an employee separates employment from the City, group insurance benefits 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 foster child
- A newborn (up to age 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 26. An over-age dependent may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Please Note: If self-funded, confirm entity's medical eligibility since it may be different than the standard.

Dental Coverage: A dependent child may be covered through end of calendar year in which child turns age 26 if primarily dependent upon the employee for support, and living in their home or a full-time or part-time student.

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

Disabled Dependents

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

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

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



Group Insurance Eligibility *(Continued)*

Taxable Dependents

Employees covering adult children under their 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 the child reaches age 26. Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which they reach age 30, imputed income must be reported on the employee's W-2 for that entire tax year. Imputed income is the dollar value of insurance coverage attributable to covering the adult child. Note: There is no imputed income if an adult child is eligible to be claimed as a dependent for federal income tax purposes on the employee's tax return. Contact Human Resources for further details if covering an adult child who will turn 27 any time during the upcoming calendar year or for more information.

Qualifying Events and IRS Code Section 125

IRS Code Section 125

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

Under certain circumstances, you may be allowed to make changes to your benefit elections during the plan year, if the event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of 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)
- Employee, employee's spouse or dependent(s) terminate or start employment
- An increase or decrease in employees work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)



IMPORTANT

If you experience a qualifying event, **you must contact Human Resources within 30 days of the qualifying event** to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied and the employee may be responsible both legally and financially for any claim and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place in accordance with the carrier's policies and procedures. You will be required to furnish valid documentation supporting a change in status or "Qualifying Event."



Medical Insurance

The City offers medical insurance through United Healthcare to benefit eligible employees. The cost per pay period for coverage is listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plan, please refer to the plan’s summary of coverage document or contact United Healthcare’s Customer Service.

Medical Insurance Premiums United Healthcare – Choice Plus Plan 3 24 Payroll Deductions – Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$51.00
Employee + Spouse	\$113.22
Employee + Child(ren)	\$92.82
Employee + Family	\$156.57

Other Available Plan Resources

United Healthcare offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please refer to the summary of coverage document, contact UHC’s customer service at (877) 816-3596 or visit www.myuhc.com.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the medical plan is **provided as a supplement** to this booklet which is being distributed to new hires and existing employees during open enrollment. The summary is an important item in understanding the benefit options. A free paper copy of the SBC document may be requested or is available as follows:

From: Human Resources
Address: 50 Bald Eagle Drive
 Marco Island, FL 34145
Phone: (239) 389-3970
Email: lsanford@cityofmarcoisland.com
At Website URL: www.cityofmarcoisland.com
Benefits Resource Center: www.mybentek.com/cityofmarcoisland

The SBC is only a summary of the plan’s coverage. A copy of the plan document, policy or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the actual group certificate of coverage can be reviewed and obtained by contacting Human Resources or at the following web addresses: www.cityofmarcoisland.com or www.mybentek.com/cityofmarcoisland.

If employees have any questions about the plan offerings or coverage options, please contact Human Resources at (239) 389-3970.



United Healthcare – Choice Plus Plan 3 At-A-Glance

Network	Choice Plus	
Calendar Year Deductible (CYD)	In-Network	Out-of-Network*
Single	\$500	\$1,000
Family	\$1,000	\$2,000
Coinsurance		
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Limit		
Single	\$2,500	\$5,000
Family	\$5,000	\$10,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician (PCP) Office Visit	\$20 Copay	30% After CYD
Specialist Office Visit	\$40 Copay	30% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab (Blood Work): LabCorp**	No Charge	30% After CYD
X-rays	No Charge	30% After CYD
Advanced Imaging (MRI, PET, CT)	10% After CYD	30% After CYD
Outpatient Surgery in Surgery Center	10% After CYD	30% After CYD
Physician Services at Surgical Center	10% After CYD	30% After CYD
Hospital Services		
Inpatient Hospital (Per Admission)	10% After CYD	30% After CYD
Outpatient Hospital (Per Visit)	10% After CYD	30% After CYD
Physician Services at Hospital	10% After CYD	30% After CYD
Emergency Room (Per Visit; Waived if Admitted)	\$150 Copay	\$150 Copay
Urgent Care (Per Visit)	\$50 Copay	30% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospitalization (Per Admission)	10% After CYD	30% After CYD
Outpatient Services (Per Visit)	\$20 Copay	30% After CYD
Prescription Drugs (Rx)		
Tier 1	\$10 Copay	\$10 Copay
Tier 2	\$35 Copay	\$35 Copay
Tier 3	\$60 Copay	\$60 Copay
Mail Order Drug (90 Day Supply)	\$25/\$87.50/\$150 Copay	Not Covered



Locate a Provider

To search for a participating provider, contact United Healthcare's Customer Service or visit www.uhc.com. When completing the necessary search criteria, select **Choice Plus** for the network type.



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 plan's summary of coverage document.

****LabCorp** is the preferred lab for bloodwork through United Healthcare. When using a lab other than LabCorp, please be sure to confirm they are contracted with United Healthcare's Choice Plus Network prior to receiving services.



Dental Insurance

Delta Dental PPO Plan

The City offers dental insurance through Delta Dental to benefit eligible employees. The cost per pay period for coverage is listed in the premium table and a brief summary of benefits is provided below. For more detailed information about the dental plan, please refer to the plan's summary plan document or contact Delta Dental's Customer Service.

Dental Insurance Premiums Delta Dental – PPO Dental Plan 24 Payroll Deductions – Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee	\$13.28
Employee + Spouse	\$26.53
Employee + Child(ren)	\$28.14
Employee + Family	\$43.40

In-Network Benefits

The PPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Delta Dental. These participating dental providers have contractually agreed to accept Delta Dental's contracted fee or "allowed amount." This fee is the maximum amount a Delta 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: If a member is not able to use a Delta Dental PPO provider, then services can be received from a Delta Dental Premier Provider. Delta Dental Premier Providers are considered out-of-network dentists. These dentists have agreed to accept Delta Dental's Maximum Plan Allowance (MPA) for each single procedure; however, the provider may still bill for the difference of the MPA and the Premier Dental Agreement amount. The member is responsible for verifying whether the treating dentist is a PPO Dentist or Premier Dentist.

Out-of-Network Benefits

Out-of-network benefits are used when members receive services by a non-participating Delta Dental provider. Delta Dental reimburses out-of-network services based on what it determines is 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 will pay the out-of-network benefit plus the difference between the amount that Delta Dental reimburses (MRC) for such services and the amount charged by the dentist. This is known as balance billing. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The dental PPO plan requires a \$50 individual or a family \$150 deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventative services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the dental PPO plan will pay for each covered member is \$1500 for in-network or out-of-network services combined. All services including Class I: Diagnostic & Preventative Services accumulate towards the benefit maximum.

Please Note the Following:

- The plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods. Please contact Delta Dental's Customer Service for additional information.
- Each covered family member may receive up to 2 routine cleanings per consecutive 12 months under the preventative benefit.
- Waiting periods and age limitations for certain services may apply.
- For any dental work expected to cost \$500 or more, the plan will provide a "Pre-Treatment Estimate" upon the request of your dental provider. This will assist you with determining your approximate out-of-pocket costs should you have the dental work performed.

Delta Dental | Customer Service: (800) 521-2651 | www.deltadentalins.com



Delta Dental – PPO Plan At-A-Glance

Network	Delta Dental PPO	
Calendar Year Deductible (CYD)	In-Network	Out-of-Network
Per Family		\$50
Per Family		\$150
Waived for Class I Services?		Yes
Calendar Year Benefit Maximum		
Per Member		\$1,500
Class I Services: Diagnostic & Preventative		
Routine Oral Exam (2 Per Consecutive 12 Months)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)
Routine Cleanings (2 Per Consecutive 12 Months)		
Fluoride Treatments (Under Age 16, 2 Times Per Consecutive 12 Months)		
Bitewing X-rays (1 Per Calendar Year)		
Complete X-rays (1 Per 36 Months)		
Class II Services: Basic Restorative		
Fillings (Amalgam & Anterior Composite)	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD (Subject to Balance Billing)
Simple Extractions		
Endodontics		
Periodontal Services		
Emergency Treatment / General Services		
Class III Services: Major Restorative		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD (Subject to Balance Billing)
Dentures		
Bridges		
Oral Surgery		
Class IV Services: Orthodontia		
Lifetime Maximum		\$1,000
Benefit (Dependent Children Up To Age 19)	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)



Locate a Provider

To search for a participating provider, contact customer service or go to www.deltadentalins.com. When completing the search criteria, select "DeltaDental PPO" as your network type.



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.*



Vision Insurance

United Healthcare Vision Plan

The City offers vision insurance through United Healthcare to benefit eligible employees. The cost per pay period for coverage is listed in the premium table and a brief summary of benefits is provided below. For more information about the vision plan, please refer to the plan's summary of coverage document or contact United Healthcare's Customer Service.

Vision Insurance Premiums
United Healthcare – Vision Plan
24 Payroll Deductions – Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$3.29
Employee + Spouse	\$8.83
Employee + Child(ren)	\$8.83
Employee + Family	\$8.83

In-Network Benefits

The vision plan offers employees and their covered dependents coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered employees and their dependents can select any network provider who participates in the United Healthcare Vision 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

Employees and their covered dependents may also choose to receive services from vision providers who do not participate in the United Healthcare. When going out of network, the provider will require payment at the time of appointment. United Healthcare 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.

Claims Address:
P.O. Box 30978 | Salt Lake City, UT 84130 | Fax: (248) 733-6060

United Healthcare Vision
Customer Service: (800) 638-3120 | www.myuhcvision.com



United Healthcare Vision Plan At-A-Glance

Network	United Healthcare Vision	
Services	In-Network	Out-of-Network
Eye Exam	\$10 Copay	Up to \$40 Reimbursement
Frequency of Services		
Examination		12 Months
Lenses		12 Months
Frames		24 Months
Contact Lenses		12 Months
Lenses		
Single	No Charge	Up to \$40 Reimbursement
Bifocal	No Charge	Up to \$60 Reimbursement
Trifocal	No Charge	Up to \$80 Reimbursement
Frames		
Private Practice Provider	Up to \$50 Allowance	Up to \$45 Reimbursement
Retail Allowance	Up to \$130 Allowance	Up to \$45 Reimbursement
Contact Lenses*		
Non-Elective (Medically Necessary)	No Charge	Up to \$210 Reimbursement
Covered in Full Elective (Fitting, Follow-up & Lenses)**	No Charge	Up to \$150 Reimbursement
Non-covered in Full Elective (Fitting, Follow-up & Lenses)	Up to \$150 Allowance	Up to \$150 Reimbursement



Locate a Provider

To search for a participating provider, contact United Healthcare's Customer Service or visit www.uhc.com. When completing the necessary search criteria, select **United Healthcare Vision** for the network.



Plan References

**Contact lenses are in lieu of spectacle lenses and a frame.*

***Please contact United Healthcare's Customer Service for a list of covered in full elective contact lenses.*



Important Notes

The network provider copay will apply once if frames and lenses are purchased at the same time.



Flexible Spending Account

The City offers Flexible Spending Accounts (FSA) administered through Paychex. The FSA plan year is from January 1 through December 31.

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

The City offers: Health Care Reimbursement FSA and Dependent Care Reimbursement FSA

- **Health Care Reimbursement FSA:** The Health Care FSA covers medical, dental, and vision expenses that are not paid by insurance.
- **The Dependent Care Reimbursement FSA:** This covers day care expense for qualified dependents that are necessary for the employee and legal spouse, if married, to work.

Health Care FSA

This account allows participants to set aside up to an annual maximum of \$2,550. 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 employees 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 participants to set aside up to an annual maximum of \$5,000 if you are single or married and file a joint tax return (\$2,500 if you are married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and adults.

Please note that if a family's 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 that is physically or mentally incapable of self-care and spends at least 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 the participant's paycheck for the Dependent Care FSA.

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

- ✓ 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
- ✓ Prescription drugs
- ✓ Sunscreen
- ✓ Wheelchairs

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



Flexible Spending Account *(Continued)*

FSA Guidelines

- Any unused funds after a plan year (or grace period) ends and all claims have been filed cannot be returned to you nor can the funds be carried forward to the next plan year.
- You have a grace period at the end of the plan year from January 1 – March 15. The grace period allows additional time to incur claims and spend any unused funds on eligible expenses after the plan year ends (December 31).
- You have a run out period at the end of the plan year through March 31 to claim reimbursement for eligible expenses incurred during your period of coverage within the plan year (or grace period).
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employees and their dependents cannot be reimbursed for services they have not received.
- Employees and their dependents cannot receive insurance benefits or any other compensation for expenses which are 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 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. Paychex may request supporting documentations 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 Paychex.

HERE'S HOW IT WORKS!



An employee earning \$30,000 elects to place \$1,000 into a Health Care FSA. The payroll deduction is \$41.66 based on a 24 pay period schedule. As a result, the insurance premiums and 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 medical and/or dependent care expenses. IRS regulations state that any unused funds will remain in your FSA after a plan year ends (or grace period) 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."

Paychex | Customer Service: (877) 244-1771 | www.benefits.paychex.com



Basic Life and AD&D Insurance

Basic Term Life

All benefit eligible employees may elect to purchase Basic Term Life Insurance through The Standard in the amount of \$50,000. The cost for this coverage is \$14.25 a month, \$7.13 per pay period.

All benefit eligible employees may elect to purchase Basic Term Life Insurance through The Standard in the amount of \$50,000.

Accidental Death & Dismemberment

Included with the Basic Term Life Insurance is 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.

Coverage amounts are subject to the age reduction schedule of 35% at age 65, 50% at age 70, and 65% at age 75.

Always remember to keep your beneficiary forms updated. Beneficiary forms are available in Human Resources.

The Standard | Customer Service: (800) 348-3226 | www.standard.com

Additional Life Insurance

Additional Employee Life Insurance

All benefit eligible employees 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 and AD&D coverages. Additional Life Insurance offers coverage for yourself, spouse or child(ren) at different benefit levels. You must purchase Basic Term Life in order to purchase Additional Life Insurance for yourself or your qualified family members.

New Hires can purchase Additional Employee Life Insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of \$80,000.

- Units can be purchased in increments of \$10,000 to a maximum of \$300,000.
- Benefit amounts are subject to the following age reduction schedule:
 - > 35% at age 65
 - > 50% at age 70
 - > 65% at age 75
- Premium calculation:
 - > Elected Coverage ÷ \$1,000 x Employee Rate (see table on the next page) = Monthly Premium.



Additional Life Insurance *(Continued)*

Additional Spouse Life Insurance

New Hires can purchase Additional Spouse Life Insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of \$10,000.**

- Employees **must** participate in the additional plan for their spouse to participate.
- Units can be purchased in increments of \$5,000, not to exceed a maximum of \$150,000, however coverage **cannot exceed** 50% of the employee's Additional Life coverage amount.
- Spouse Life Insurance coverage will be reduced as the employee ages by 35% at age 65, 50% at age 70, and 65% at age 75.
- Premium calculation (based on the employee's age): Elected Coverage ÷ \$1,000 x Spouse Rate (see table to the right) = Monthly Premium.

Dependent Child(ren) Life Insurance

- Employees **must** participate in voluntary plan for dependent children to participate.
- Coverage is \$10,000 for eligible children. Late applications are subject to medical underwriting approval.
- Employees may cover their children from live birth through age 20 (24 if a registered full-time student).
- Cost for Dependent Child(ren) Life Insurance is \$1.00 a month regardless of the number of eligible children covered.

Additional Life Monthly Rates

Age Bracket	Employee/Spouse <i>(Per \$1,000)</i>
< 30	\$0.08
30-34	\$0.08
35-39	\$0.11
40-44	\$0.16
45-49	\$0.26
50-54	\$0.41
55-59	\$0.54
60-64	\$0.82
65-69	\$1.39
70-74	\$2.48
75+	\$9.37

The Standard | Customer Service: (800) 348-83226 | www.standard.com



Short Term Disability

All benefit eligible employees may elect to purchase Short Term Disability (STD) insurance through The Standard. The STD benefit pays you a percentage of your weekly earnings if you become disabled due to an illness or non-work related injury.

The STD plan offers a benefit of 60% of your weekly earnings, subject to a maximum benefit of \$1,000 per week.

STD Plan Summary

- The STD plan offers a benefit of 60% of your weekly earnings, subject to a maximum benefit of \$1,000 per week.
- An employee must be ill or injured for 29 days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will commence on the 30th day of illness or injury.
- The maximum benefit period is 180 days (you must satisfy the 29-day elimination period before you can collect benefits).
- Benefits may be reduced by other income.

Short Term Disability Monthly Rates

Age Bracket <i>(As of November 1st)</i>	Rate <i>(Per \$10 of STD Benefit)</i>
< 30	\$0.359
30-34	\$0.399
35-39	\$0.357
40-44	\$0.371
45-49	\$0.464
50-54	\$0.556
55-59	\$0.778
60+	\$0.943

The Standard | Customer Service: (888) 368-2859 | www.standard.com

Long Term Disability

All benefit eligible employees may elect to purchase Long Term Disability (LTD) insurance through The Standard. The LTD benefit pays you a percentage of your monthly earnings if you become disabled due to an illness or non-work related injury.

The LTD plan offers a benefit of 60% of your monthly earnings, subject to a maximum benefit of \$5,000 per month.

LTD Plan Summary

- The LTD plan offers a benefit of 60% of your monthly earnings, subject to a maximum benefit of \$5,000 per month.
- An employee must be disabled for 180 days prior to becoming eligible for benefits.
- Benefit payments will commence on the 181st day of disability.
- You may continue to be eligible for benefits if you return to work on a part-time basis.
- Benefits may be reduced by other income.
- Benefits are payable to age 65 or are based on a reduced benefit duration if the employee is disabled on or after the age of 62.
- Cost for employee is \$0.55 per \$100 of monthly earnings.

The Standard | Customer Service: (888) 937-4783 | www.standard.com



Employee Assistance Program

The City provides a comprehensive Employee Assistance Program (EAP) to you and each member of your family through Employee Assistance Services at no cost. Employee Assistance Services offers access to mental health counselors through a confidential program that is protected by State and Federal laws. The EAP program is available to help you gain a better understanding of problems that affect you, locate the best professional help for your particular problem, and decide upon a plan of action.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employees and their family members free and convenient access to a range of confidential and professional services to help them address a variety of problems that can negatively affect their well-being such as:

- ✓ Relationship Issues
- ✓ Substance Abuse
- ✓ Grief and Loss
- ✓ Parenting
- ✓ Elder Care
- ✓ Marital Problems
- ✓ Financial and Legal Issues
- ✓ Stress Management
- ✓ Job/Career Concerns

Are your services confidential?

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

Employee Assistance Services | Customer Service: (239) 450-3255

Supplemental Insurance

Aflac offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums are paid via payroll deduction. Aflac pays money directly to you, regardless of what other insurance plans you may have. Coverage is available for your spouse and children on most plans and the coverage is portable when you retire or change jobs with no increase in premiums. To learn more about these plans and / or to schedule a personal appointment, contact your local agent. Details regarding the following available plans and services are also available online.

- ✓ Accident
- ✓ Hospital Advantage
- ✓ Critical Care and Recovery
- ✓ Cancer Care

Aflac | Customer Service: (800) 992-3522 | www.aflac.com

Local Agent: Anna Wiseman | Cell: (239) 404-8894 | Office: (239) 348-9944

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