# Contact Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Customer Service</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Insurance</td>
<td>Cigna</td>
<td>(866) 494-2111</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td>Prescription Drug Coverage &amp; Mail-Order Program</td>
<td>Cigna/Express Scripts Pharmacy</td>
<td>(800) 835-3784</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>Virtual Care</td>
<td>Cigna MDLIVE</td>
<td>(888) 726-3171</td>
<td><a href="http://www.MDLIVEforCigna.com">www.MDLIVEforCigna.com</a></td>
</tr>
<tr>
<td>Health Reimbursement Account</td>
<td>Eagles, Benefits by Design</td>
<td>(800) 726-5603</td>
<td><a href="http://www.myflexonline.com">www.myflexonline.com</a></td>
</tr>
<tr>
<td>Dental Insurance</td>
<td>Principal</td>
<td>(800) 247-4695</td>
<td><a href="http://www.principal.com">www.principal.com</a></td>
</tr>
<tr>
<td>Vision Insurance</td>
<td>Superior Vision</td>
<td>(800) 507-3800</td>
<td><a href="http://www.superiorvision.com">www.superiorvision.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Health Advocate</td>
<td>(877) 851-1631</td>
<td><a href="http://www.healthadvocate.com/standard6">www.healthadvocate.com/standard6</a></td>
</tr>
<tr>
<td>Basic Life and AD&amp;D Insurance</td>
<td>The Standard</td>
<td>(800) 368-1135</td>
<td><a href="http://www.standard.com">www.standard.com</a></td>
</tr>
<tr>
<td>Voluntary Short Term Disability</td>
<td>Mutual of Omaha</td>
<td>(800) 877-5176</td>
<td><a href="http://www.mutualofomaha.com">www.mutualofomaha.com</a></td>
</tr>
<tr>
<td>Supplemental Insurance</td>
<td>Aflac</td>
<td>Robert Royer</td>
<td><a href="http://www.aflac.com">www.aflac.com</a></td>
</tr>
<tr>
<td>Travel Assistance Program</td>
<td>Assist America</td>
<td>(866) 268-7587</td>
<td><a href="http://www.standard.com/travel">www.standard.com/travel</a></td>
</tr>
</tbody>
</table>

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This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Fellsmere 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 City of Fellsmere provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the City’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 Finance Department.

Group Insurance Eligibility

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

Employee Eligibility

Employees are eligible to participate in the City’s insurance plans if they are full-time employees working more than 30 hours per week. Coverage will be effective the first of the month following 30 consecutive days of employment. For example, if an 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 City, insurance will continue through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child(ren) of the participant or spouse. The term “child” includes any of the following:

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

Dependent Age Requirements

- **Medical Coverage**: A dependent child may be covered through the end of the month in which the child turns age 26.
- **Dental Coverage**: A dependent child may be covered through end of the month in which the child turns age 26.
- **Vision Coverage**: A dependent child may be covered through end of month in which the child turns age 26.

Disabled Dependents

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

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

Proof of disability will be required upon request. Please contact the Finance Department if further clarification is needed.
Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

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

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

**Medical Insurance**

_Cigna Open Access Plus HDHP Plan_

26 Payroll Deductions — Per Pay Period Cost

<table>
<thead>
<tr>
<th>Tier of Coverage</th>
<th>Employee Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$120.54</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$111.50</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$171.77</td>
</tr>
</tbody>
</table>

_Cigna_ | Customer Service: (866) 494-2111 | www.cigna.com

Virtual Care

Cigna provides access to virtual care 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 nonemergency medical issues. Virtual care should be considered when employee’s primary care doctor is unavailable, after-hours or on holidays for nonemergency needs. Many urgent care ailments can be treated with virtual care, such as:

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

Virtual care doctors do not replace your primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact Cigna.

_Cigna MDLIVE_  
Customer Service: (888) 726-3171 | www.MDLIVEforCigna.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 available as follows:

From: Finance Department  
Address: 22 S. Orange Street  
Fellsmere, FL 32948  
Phone: (772) 571-1616  
Email: financedirector@cityoffellsmere.org

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 Finance Department.

If there are any questions about the plan offerings or coverage options, please contact the Finance Department at (772) 571-1616.
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 (866) 494-2111, or visit www.cigna.com.

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 log on to 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
- Tobacco Cessation
- Alternative Medicine

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 that include free audio, video and printed information on aging, women’s health, nutrition, surgery and specific medical conditions to help weigh the risks and advantages of treatment options. The call is free and is strictly confidential.

Ginger

Stress impacts everyone — in and out of the workplace. Ginger behavioral health services offer coaching as a first level of support to build resilience of everyday stress producers through techniques and motivational interviewing to understand each members’ needs and create a plan. Ginger behavioral health coaches are available on-demand via text-based chats, self-guided learning activities and content, and video-based therapy and psychiatry to help members reduce stress, reach goals and feel supported any time of the day or night. Members can work with a coach on:

- Achieving goals
- Stress management
- Building self-esteem
- Improving communication
- Work life balance
- Recovering from loss

Support is available anytime 24/7/365, on mobile devices, for a variety of mental health challenges — all from the privacy of any smartphone. Coaches can assist employee on understanding EAP benefits available to members and also may recommend adding a therapist or psychiatrist to the care team.

Cigna | www.ginger.com/cigna
# Cigna Open Access Plus HDHP Plan At-A-Glance

<table>
<thead>
<tr>
<th>Network</th>
<th>Open Access Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible (CYD)</strong></td>
<td>In-Network</td>
</tr>
<tr>
<td>Single</td>
<td>$3,250</td>
</tr>
<tr>
<td>Family</td>
<td>$6,500</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Member Responsibility</td>
</tr>
<tr>
<td><strong>Calendar Year Out-of-Pocket Limit</strong></td>
<td>Single</td>
</tr>
<tr>
<td>Family</td>
<td>$13,100</td>
</tr>
<tr>
<td><strong>What Applies to the Out-of-Pocket Limit?</strong></td>
<td>Deductible, Coinsurance, Copays and Rx</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP) Office Visit</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Virtual Care</td>
<td>10% After CYD</td>
</tr>
<tr>
<td><strong>Non-Hospital Services; Freestanding Facility</strong></td>
<td></td>
</tr>
<tr>
<td>Clinical Lab (Bloodwork)**</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>X-rays</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Advanced Imaging (MRI, PET, CT) - Per Scan</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Outpatient Surgery in Surgical Center</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Physician Services at Surgical Center</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>10% After CYD</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital (Per Admission)</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Outpatient Hospital (Per Visit)</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Physician Services at Hospital</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Emergency Room (Per Visit; Waived if Admitted)</td>
<td>10% After CYD</td>
</tr>
<tr>
<td><strong>Mental Health/Alcohol &amp; Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services (Per Admission)</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Outpatient Services (Per Visit)</td>
<td>10% After CYD</td>
</tr>
<tr>
<td>Outpatient Office Visit</td>
<td>10% After CYD</td>
</tr>
<tr>
<td><strong>Prescription Drugs (Rx)</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td>$10 After CYD</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$30 After CYD</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$50 After CYD</td>
</tr>
<tr>
<td>Mail Order Drug (90-Day Supply)</td>
<td>2.5x Retail Copay</td>
</tr>
</tbody>
</table>

*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, please confirm they are contracted with Cigna’s Open Access Plus network prior to receiving services.
Health Reimbursement Account

The City provides employees who participate in the Cigna Open Access Plus HDHP plan, a Health Reimbursement Account (HRA) through Eagles, Benefits by Design. HR monies are funded by the City and can be used for any qualified medical, dental and vision expenses such as deductibles, copays and coinsurance for physician services, hospital services, prescription drugs, etc.

HRA Funding Allotment

HRA Funding for the 2021-2022 Plan Year is as follows:

- Employees enrolled in the City’s medical plan will receive:
  - Up to $3,000 for Employee Only
  - Up to $6,000 for Employee + Dependents
- A percentage of unused amounts in the HRA can be carried forward for use in the next Plan Year.
- HRA dollars may also be used for Dental and Vision services ONLY when enrolled in medical.

Retain Receipts

During the year, employee should keep all receipts and documentation for prescriptions and medical, dental, and vision related expenses if needed to verify a claim for Eagles, Benefits by Design or for IRS tax purposes. If asked to produce documentation, a valid Explanation of Benefits (EOB) and receipt of payment for the services rendered will be sufficient.

How to Check Available HRA Balance

Balance, activity and account history is available anytime online at www.myflexonline.com or by calling Eagles, Benefits by Design at (800) 726-5603.

Expenses Eligible for Reimbursement

Employee may request reimbursement of expenses for employee or covered dependent(s). Eligible expenses must be necessary for the diagnosis, treatment, cure, mitigation or prevention of a specific medical, dental and vision condition. Cosmetic expenses are not eligible for reimbursement. Reimbursement checks will be issued to employee throughout the year for incurred expenses up to the maximum annual benefit amount. Employee has the option to have reimbursement checks direct deposited into employee’s bank account. For more information regarding eligible expenses, visit Eagles, Benefits by Design online at www.myflexonline.com.

File a Claim

Paper Claim
Employee may submit claim forms to Eagles, Benefits by Design and must include a copy of carrier’s Explanation of Benefits or receipts for eligible medical services received. Claim forms can be submitted via email to claims@eaglesbenefits.com or via mail to address listed below.

Claims Mailing Address
2336 SE Ocean Blvd., Ste 301 | Stuart, FL 34996-3310
Claims E-Mail Address
claims@eaglesbenefits.com

Eagles, Benefits by Design
Customer Service: (800) 726-5603 | www.myflexonline.com

All claims must be filed within three (3) months after the plan year ends, or 30 days from the date employee becomes ineligible to file for expenses incurred while participating during the plan year.
Dental Insurance

Principal Dental PPO Plan

The City offers dental insurance through Principal 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 Principal’s customer service.

**Dental Insurance – Principal Dental PPO Plan**

**26 Payroll Deductions – Per Pay Period Cost**

<table>
<thead>
<tr>
<th>Tier of Coverage</th>
<th>Employee Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$9.81</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$10.62</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$20.49</td>
</tr>
</tbody>
</table>

**In-Network Benefits**

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

**Out-of-Network Benefits**

Out-of-network benefits are used when members receive services by a non-participating Principal Plan Dental provider. Principal reimburses out-of-network services based on what it determines is the Maximum Allowable Charge (MAC). The MAC 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 Principal’s MAC and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

**Calendar Year Deductible**

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

**Calendar Year Benefit Maximum**

The maximum benefit (coinsurance) the Dental PPO plan will pay for each covered member is $1,000 for in-network or 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.

**Rollover Benefit**

The rollover benefit allows member the ability to retain a portion of the previous years unused Benefit Maximum for use in the current or future years. If member has received at least one (1) procedure and has used $500 or less of benefits in the Calendar Year, the balance of any unused benefits will rollover into the next Calendar Year up to a maximum amount of $500 per year or $1,000 total. If member does not receive at least one (1) procedure in any year, any current or previous amount rolled over for that insured member would be forfeited. This rollover benefit allows members the opportunity to increase the Calendar Year Benefit Maximum for future extensive or major procedures.

Principal | Customer Service: (800) 247-4695 | www.principal.com
### Principal Dental PPO Plan At-A-Glance

<table>
<thead>
<tr>
<th>Network</th>
<th>Principal Plan Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible (CYD)</strong></td>
<td>In-Network and Out-of-Network</td>
</tr>
<tr>
<td>Per Member</td>
<td>$50</td>
</tr>
<tr>
<td>Per Family</td>
<td>$150</td>
</tr>
<tr>
<td>Waived for Class I Services?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Calendar Year Benefit Maximum</strong></td>
<td>In-Network</td>
</tr>
<tr>
<td>Per Member</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Class I Services: Preventive Procedures
- **Routine Oral Exam (2 Per Calendar Year)**
- **Routine Cleanings (2 Per Calendar Year)**
- **Bitewing X-rays (2 Sets Per Calendar Year)**

| Plan Pays: 100% Deductible Waived | Plan Pays: 80% Deductible Waived (Subject to Balance Billing) |

### Class II Services: Basic Procedures
- **Complete X-rays (Once Every 60 Months)**
- **Fillings (Amalgam or Composite)**
- **Deep Cleaning**
- **Simple Extractions**
- **Oral Surgery**
- **Anesthesia**
- **Endodontics (Root Canal)**
- **Periodontics (Non-Surgical Procedures)**

| Plan Pays: 80% After CYD | Plan Pays: 60% After CYD (Subject to Balance Billing) |

### Class III Services: Major Procedures
- **Periodontics (Surgical Procedures)**
- **Crowns**
- **Bridges**
- **Dentures**

| Plan Pays: 50% After CYD | Plan Pays: 40% After CYD (Subject to Balance Billing) |

---

**Locate a Provider**
To search for a participating provider, contact Principal’s customer service or visit www.principal.com. When completing the necessary search criteria, select Principal Plan Dental 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 basic or major dental services, the plan will provide a Dental Treatment Plan 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

Superior Vision Plan

The City offers vision insurance through Superior Vision 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 Superior Vision's customer service.

Vision Insurance — Superior Vision Plan

<table>
<thead>
<tr>
<th>Tier of Coverage</th>
<th>Employee Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$1.75</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$1.14</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$3.10</td>
</tr>
</tbody>
</table>

Out-of-Network Benefits

Employees and covered dependent(s) may choose to receive services from vision providers who do not participate in the Superior National network. When going out of network, the provider will require payment at the time of appointment. Superior Vision 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.

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, covered employee and dependent(s) may select any network provider who participates in the Superior National 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.

Superior Vision

Customer Service: (800) 507-3800 | www.superiorvision.com
### Superior Vision Plan At-A-Glance

<table>
<thead>
<tr>
<th>Network</th>
<th>Superior National</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Contact Lens Exam</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Materials</td>
<td>$25 Copay</td>
</tr>
<tr>
<td><strong>Frequency of Services</strong></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses</td>
<td></td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$25 Copay</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
</tr>
<tr>
<td>Allowance</td>
<td>Up to $100 Retail Allowance After $25 Materials Copay</td>
</tr>
<tr>
<td>*<em>Contact Lenses</em></td>
<td></td>
</tr>
<tr>
<td>Non-Elective (Medically Necessary)</td>
<td>No Charge</td>
</tr>
<tr>
<td>Elective</td>
<td>Up to $100 Retail Allowance</td>
</tr>
<tr>
<td>Fitting Follow-Up</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Specialty</td>
<td>$50 Retail Allowance After $25 Copay</td>
</tr>
</tbody>
</table>

### Locate a Provider
To search for a participating provider, contact Superior Vision's customer service or visit www.superiorvision.com. When completing the necessary search criteria, select Superior National network.

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

### Important Notes
Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.
Employee Assistance Program

The City cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Health Advocate. 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?

An Employee Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member’s well-being. Coverage includes six (6) face-to-face counseling sessions (per person/per issue/per year), telephonic consultation, online material/tools and webinars. EAP offers counseling services on issues such as:

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

Are services confidential?

Yes. Receipt of EAP services are completely confidential. If 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 or manager. The referring supervisor or manager will not receive specific information regarding the referred employee’s case. The supervisor or manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides Basic Term Life insurance for all eligible employees at no cost, through The Standard. Employees are provided a benefit amount equal to one (1) times employee annual salary, up to a maximum of $150,000.

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.

Accidental Death & Dismemberment Insurance

Also at no cost to the employee, the City provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit, partial benefits may also be payable.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- Reduces to 67% of the benefit amount at age 65
- Reduces to 34% of the benefit amount at age 70

Always remember to keep beneficiary information updated.
Beneficiary information may be updated at anytime through the Finance Department.

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

Health Advocate
Voluntary Short Term Disability

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

Voluntary Short Term Disability (STD) Benefits

- STD provides a benefit of 60% of employee’s weekly earnings up to a benefit maximum of $500 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 11 weeks.
- Benefits may be reduced by other income.
- Disability benefits are not taxable.

Mutual of Omaha
Customer Service: (800) 877-5176 | www.mutualofomaha.com

Supplemental Insurance

Aflac offers a variety of supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction. Aflac pays money directly to employee, regardless of what other insurance plans employee may have. To learn more about these Aflac plans and/or schedule a personal appointment, contact the local Aflac Agent.

- Cancer Care Policy
- Guarantee Issue Short Term Disability
- Hospital Advantage Policy
- Life Protector
- Personal Accident Indemnity Plan
- Personal Disability Income Protector

Aflac
Agent: Robert Royer | Phone: (866) 268-7587 | Cell: (781) 752-6829
Email: robert_royerii@us.aflac.com | www.aflac.com

Travel Assistance Program

The Travel Assistance program is available to all eligible employees covered by the City’s group Life Insurance through The Standard. Employees’ dependents, including a spouse and dependent children, married or unmarried through age 25, are covered participants under the program as well. The program is designed to assist with information and referrals, transportation, and evacuation services that may arise during travel, as well as assistance with pre-travel preparation. Travel Assistance provides an ID card with the appropriate contact information for assistance that member can keep with them when they travel.

- Pre-Trip Assistance: Currency exchange information, health hazards and inoculation requirements, passport, and visa information, and more.
- Travel Assistance Services: Credit card and ticket replacement, passport and document replacement, emergency message service, missing baggage assistance, and more.
- Medical Assistance Services: Locate medical care, translation, and interpretation services, and more.
- Emergency Transportation Services: Emergency evacuation, medically necessary repatriation, return of dependent children, vehicle return, and more.
- Personal Security Services: Security intelligence and evacuation services.

Travel Assistance
Customer Service: U.S., Canada, Puerto Rico, U.S. Virgin Islands, and Bermuda: (800) 872-1414
All other locations worldwide: +1 (609) 986-1234 | Text: (609) 334-0807
Email: medservices@assistamerica.com | www.standard.com/travel