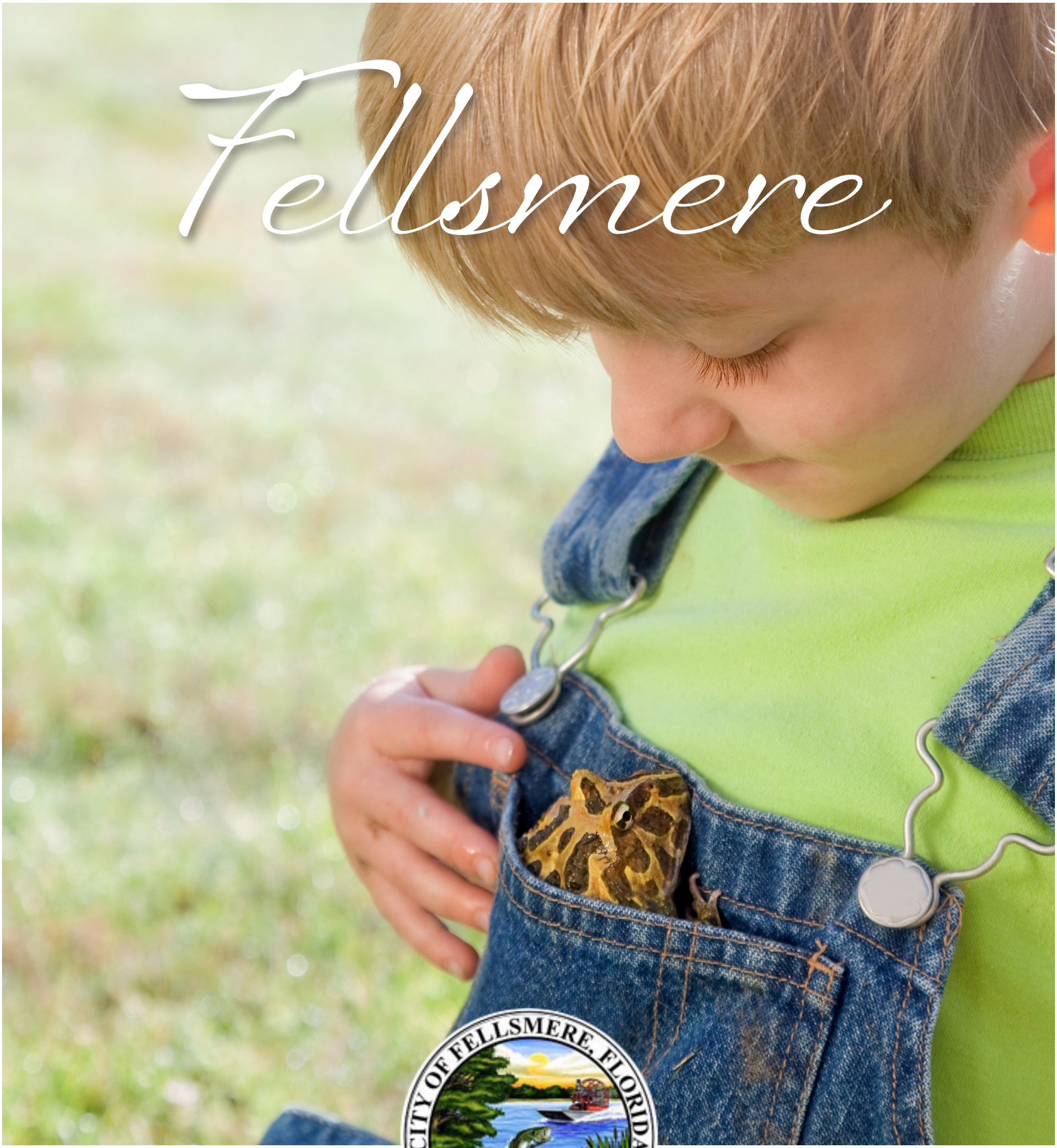

Fellsmere

2021 2022

Employee Benefit Highlights

Contact Information

	Finance Department	Finance Department	Phone: (772) 571-1616
		Putnam Moreman Director of Finance and Accounting	Phone: (772) 646-6304 Email: financedirector@cityoffellsmere.org
		Claudia M. Alvarado Senior Accountant	Phone: (772) 646-6307 Email: accountclerk2@cityoffellsmere.org
	Medical Insurance	Cigna	Customer Service: (866) 494-2111 www.cigna.com
	Prescription Drug Coverage & Mail-Order Program	Cigna/Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
	Virtual Care	Cigna MDLIVE	Customer Service: (888) 726-3171 www.MDLIVEforCigna.com
HRA	**Health Reimbursement Account**	Eagles, Benefits by Design	Customer Service: (800) 726-5603 Fax: (772) 334-7059 www.myflexonline.com
	Dental Insurance	Principal	Customer Service: (800) 247-4695 www.principal.com
	Vision Insurance	Superior Vision	Customer Service: (800) 507-3800 www.superiorvision.com
	Employee Assistance Program	Health Advocate	Customer Service: (877) 851-1631 www.healthadvocate.com/standard6
	Basic Life and AD&D Insurance	The Standard	Customer Service: (800) 368-1135 www.standard.com
	Voluntary Short Term Disability	Mutual of Omaha	Customer Service: (800) 877-5176 www.mutualofomaha.com
	Supplemental Insurance	Aflac	Agent: Robert Royer Phone: (866) 268-7587 | Cell: (781) 752-6829 Email: robert_royerii@us.aflac.com www.aflac.com
	Travel Assistance Program	Assist America	Customer Service: U.S., Canada, Puerto Rico, U.S. Virgin Islands, and Bermuda: (800) 872-1414 All other locations worldwide: +1 (609) 986-1234 Email: medservices@assistamerica.com www.standard.com/travel

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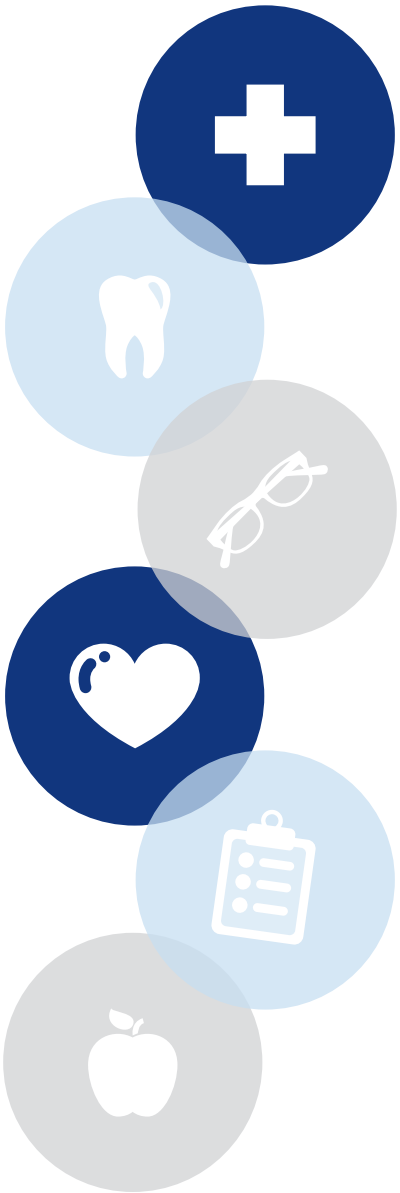

This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Fellsmere reserves the right to amend, modify or terminate the plan at any time. This booklet 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

OCTOBER 01

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

Tier of Coverage	Employee Cost
Employee	$0.00
Employee + Spouse	$120.54
Employee + Child(ren)	$111.50
Employee + Family	$171.77

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

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

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.

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

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 StoreSM 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 family members
- Review deductibles, account balances and claims
- Compare prescription drug costs
- Speed-dial Cigna Home Delivery Pharmacy™
- Store and organize all important contact info for doctors, hospitals, and pharmacies
- Add health care professionals to contact list direct from a claim or directory search
- And, much more!

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

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

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.cigna.com. When completing the necessary search criteria, select Open Access 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, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$3,250	$6,500
Family	$6,500	$13,000
Coinsurance		
Member Responsibility	10%	50%
Calendar Year Out-of-Pocket Limit		
Single	$6,550	$13,100
Family	$13,100	$26,200
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	10% After CYD	50% After CYD
Specialist Office Visit	10% After CYD	50% After CYD
Virtual Care	10% After CYD	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	10% After CYD	50% After CYD
X-rays	10% After CYD	50% After CYD
Advanced Imaging *(MRI, PET, CT)* - Per Scan	10% After CYD	50% After CYD
Outpatient Surgery in Surgical Center	10% After CYD	50% After CYD
Physician Services at Surgical Center	10% After CYD	50% After CYD
Urgent Care	10% After CYD	50% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After CYD	50% After CYD
Outpatient Hospital *(Per Visit)*	10% After CYD	50% After CYD
Physician Services at Hospital	10% After CYD	50% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	10% After CYD	10% After In-Network CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After CYD	50% After CYD
Outpatient Services *(Per Visit)*	10% After CYD	50% After CYD
Outpatient Office Visit	10% After CYD	50% After CYD
Prescription Drugs *(Rx)*		
Tier 1	$10 After CYD	Not Covered
Tier 2	$30 After CYD	Not Covered
Tier 3	$50 After CYD	Not Covered
Mail Order Drug *(90-Day Supply)*	2.5x Retail Copay	Not Covered

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. HRA 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) 723-5603.

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

Tier of Coverage	Employee Cost
Employee	$0.00
Employee + Spouse	$9.81
Employee + Child(ren)	$10.62
Employee + Family	$20.49

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

Network	Principal Plan Dental	
Calendar Year Deductible (CYD)	**In-Network and Out-of-Network**	
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum	**In-Network**	**Out-of-Network***
Per Member	$1,000	
Class I Services: Preventive Procedures		
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 80% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Calendar Year)*		
Bitewing X-rays *(2 Sets Per Calendar Year)*		
Class II Services: Basic Procedures		
Complete X-rays *(Once Every 60 Months)*	Plan Pays: 80% After CYD	Plan Pays: 60% After CYD *(Subject to Balance Billing)*
Fillings *(Amalgam or Composite)*		
Deep Cleaning		
Simple Extractions		
Oral Surgery		
Anesthesia		
Endodontics *(Root Canal)*		
Periodontics *(Non-Surgical Procedures)*		
Class III Services: Major Procedures		
Periodontics *(Surgical Procedures)*	Plan Pays: 50% After CYD	Plan Pays: 40% After CYD *(Subject to Balance Billing)*
Crowns		
Bridges		
Dentures		

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

26 Payroll Deductions – Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee	$0.00
Employee + Spouse	$1.75
Employee + Child(ren)	$1.14
Employee + Family	$3.10

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.

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.

Superior Vision

Customer Service: (800) 507-3800 | www.superiorvision.com

Superior Vision Plan At-A-Glance

Network		Superior National	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 Copay	Up to $40 Reimbursement
Contact Lens Exam		$25 Copay	Not Covered
Materials		$25 Copay	Reimbursement Based on Type of Service
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		12 Months	
Contact Lenses		12 Months	
Lenses			
Single		$25 Copay	Up to $20 Reimbursement
Bifocal		$25 Copay	Up to $40 Reimbursement
Trifocal		$25 Copay	Up to $60 Reimbursement
Frames			
Allowance		Up to $100 Retail Allowance After $25 Materials Copay	Up to $40 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $250 Reimbursement
Elective		Up to $100 Retail Allowance	Up to $60 Reimbursement
Fitting Follow-Up	Standard	$25 Copay	Not Covered
	Specialty	$50 Retail Allowance After $25 Copay	Not Covered

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.

Health Advocate
Customer Service: (877) 851-1631 | www.healthadvocate.com/standard6

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

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 Aflan 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

GEHRING® GROUP

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