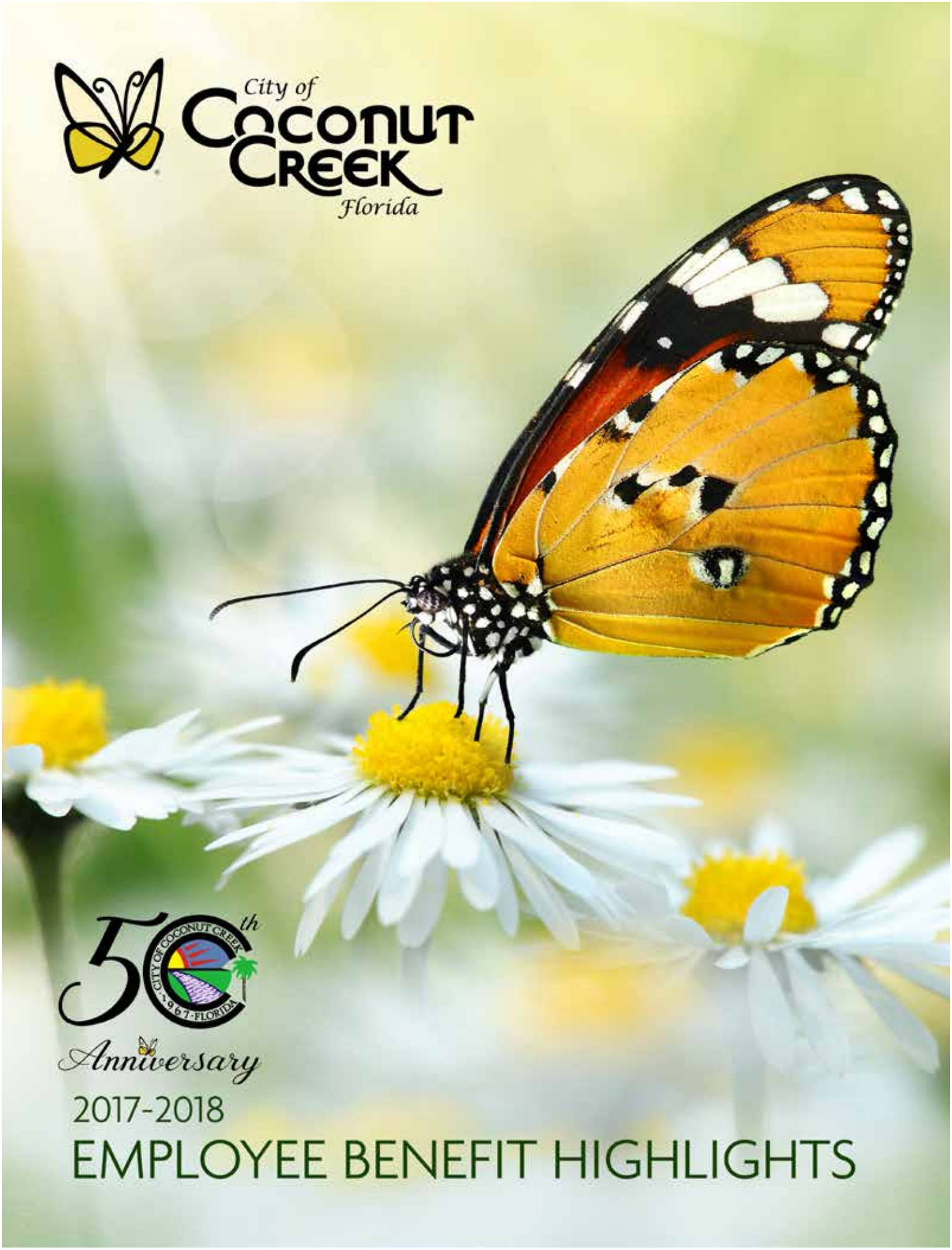
City of
Coconut Creek
Florida
50th
Anniversary
2017-2018
EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

	Human Resources and Risk Management	Main Office	Phone: (954) 973-6715
	Online Benefit Enrollment	BenTek Support	Customer Service: (888) 5-BenTek (523-6835) www.mybentek.com/coconutcreek
	Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage and Mail-Order Program	Cigna Home Delivery	Customer Service: (800) 835-3784 www.mycigna.com
HSA	**Health Savings Account**	Cigna - HSA Bank	Customer Service: (800) 244-6224 www.mycigna.com
	Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
FSA	**Flexible Spending Accounts**	Chard Snyder	Customer Service: (800) 982-7715 www.chard-snyder.com
	Basic Life and AD&D Insurance	Unum	Customer Service: (800) 421-0344 www.unum.com
	Voluntary Life Insurance	Unum	Customer Service: (800) 421-0344 www.unum.com
	Short and Long Term Disability Insurance	Unum	Customer Service: (800) 421-0344 www.unum.com
	Supplemental Insurance - Aflac	KCI Financial Services	Customer Service: (954) 443-4443 Email: lcohen@kcifinancialservices.com ccohen@kcifinancialservices.com
	Employee Assistance Program	Cigna	Customer Service: (877) 622-4327 www.cignabehavioral.com
	Long Term Care Insurance	Unum Provident	Customer Service: (866) 679-3054 www.unum.com
	Legal Plan and IDShield	Legal Shield	Customer Service: (800) 654-7757 www.legalshield.com Agent: Don Thompson Phone: (239) 549-4746
	Claims Resource Specialist	Gehring Group	Phone: (800) 244-3696 Email: coconutcreek@gehringgroup.com

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This booklet is merely a summary of your 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 Coconut Creek 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 Coconut Creek provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to the City of Coconut Creek's Civil Service Code, At-Will Employee Code, applicable Administrative Orders, applicable Collective Bargaining Agreements and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or need assistance with benefit questions or claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources and Risk Management.

2017-2018 Plan Year News

The City of Coconut Creek will have the following plan options effective October 1, 2017 – September 30, 2018.

Medical Insurance — Cigna is our medical insurance provider with two plans to choose from:

- Open Access Plus In-Network Copay Plan *(OAPIN)*
- Open Access Plus Qualified High Deductible Health Plan *(OAP HDHP)*

Opt-Out Benefit — Effective October 1, 2017, employees who opt-out of the City's group medical insurance plan and who meet the federal legislative requirements for a "conditional opt-out payment" shall continue to receive the opt-out incentive, which is currently $153.85 bi-weekly ($4,000 annually). Those who enroll in individual or marketplace plans or do not otherwise meet the requirements for a "conditional opt-out" payment shall not be eligible for any opt-out payments.

To participate in the "conditional opt-out" benefit employees are required to provide Human Resources with proof of current medical insurance indicating name of employee and employee's tax dependents before the open enrollment deadline, September 12, 2017 (or by the designated deadline for new hires or qualifying event changes throughout the plan year). If an employee participates in the "conditional opt-out," they would select "Medical Opt-Out" as their medical plan.

Please Note: *The Open Access Plus Plan (OAP) is no longer being offered by the City. If an employee is currently enrolled in the OAP Plan they may continue to participate during the 2017-2018 Plan Year, or may enroll in the OAPIN or OAP HDHP plan options.*

Health Savings Account (HSA) — Any employee enrolled in the Open Access Plus High Deductible Health Plan (OAP HDHP) will have a Health Savings Account automatically opened with HSA Bank. This is an interest bearing account and can be payroll deducted throughout the year. Unlike an FSA, the funds in HSA can roll over, can earn interest and are portable from one employer to another.

Dental Insurance — Cigna is our dental insurance provider with two plans to choose from:

- DHMO Plan
- PPO Plan

Vision Discount Plan — Those covered by any of the medical plans receive one routine vision exam from an in-network provider every 24 months at no charge. Additionally, Cigna offers a Vision Discount Plan through its Healthy Rewards Program, which is available to all members participating in any of the Cigna medical or dental plans.

Flexible Spending Accounts

Chard Snyder is the city's Flexible Spending Account (FSA) administrator. Employees may elect an FSA for Health Care or Dependent Care. If an employee has an existing FSA, the employee must re-elect FSA and enter a contribution amount during Open Enrollment.

Employer Provided Plans

- Basic Life and AD&D Insurance
- Short Term Disability Insurance
- Long Term Disability Insurance
- Employee Assistance Program *(EAP)*

Voluntary Life Insurance

Voluntary Life insurance is available for the employee, spouse, and/or dependent child(ren) through Unum Insurance Company. To enroll a spouse and/or dependent child(ren), you must enroll in Voluntary Employee Life insurance.

Voluntary Benefit Options

- Aflac *(various plans available)*
- Long Term Care
- Pre-Paid Legal and ID Shield

Online Benefit Enrollment

The City provides employees with an online benefits enrollment platform through BenTek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employee the ability to select or change their insurance benefits online during the annual open enrollment period, new hire orientation, or qualifying events.

Accessible 24 hours a day at any time during the year, employee may log in and review comprehensive information about benefit plans, and view and print a summary of benefit elections for an employee and dependent(s). Employee has access to important forms and carrier links, can report qualifying life events and review and make changes to life insurance beneficiary designations.

To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/coconutcreek**
- ✓ Sign in using a previously created user name and password or follow instructions to create a personal username and password. If the user name and/or password have been forgotten, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate to the menu in order to review current elections, learn about benefit options, and make any elections or changes.
- ✓ Employees may also update life insurance beneficiary designation(s).
- ✓ Employees have the option to print out an enrollment summary statement containing all benefit elections including life insurance beneficiary designations.

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

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

BenTek Support

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

BenTek Important Info

On the initial login page employees can find important information including how to create an account, BenTek's User Guide, and the Open Enrollment Quick Guide.

BenTek Reminder

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 October 1 through September 30.

Employee Eligibility

Full-time employees working a minimum of 30 hours per week are eligible to participate in the City's insurance plans. Coverage is effective the first of the month following 30 days of full-time employment. For example: If an employee is hired on April 11, coverage will be effective on June 1.

Termination

If an employee separates employment from the City, insurance will continue through the end of month in which the separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse, dependent child(ren) of the participant or the spouse. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A stepchild
- A foster child
- A newborn (up to age 18 months old) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse
- Domestic Partner coverage is not offered

Dependent Age Requirements

Medical Coverage: Dependent children may be covered through the end of calendar year in which they turn 26. Overage Dependents may continue to be covered on the medical plan to the end of the calendar year in which the dependent reaches the age of 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 handicapped.

Dental Coverage: Dependent children may be covered through the end of the calendar year in which they turn 26.

Disabled Dependents

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

- The dependent child 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 child is otherwise eligible for coverage under the group medical plan; and
- The dependent child has been continuously insured; and
- Coverage with the City began prior to age 26.

Proof of disability will be required upon request. Please contact the Human Resources and Risk Management Department if further clarification is required.

Taxable Dependents

Beginning January 1 of the calendar year in which the dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, that portion of the health insurance premium that is attributable to covering the overage dependent (the "OAD value") will be deducted on a post tax basis. The remaining employee contribution, if any (i.e. the amount over and above the OAD value) will continue to be deducted on a pre-tax basis. If the OAD value is greater than the payroll deduction, the additional employer subsidized portion of the value (OAD value minus payroll deduction) will be reported as imputed income to the employee and included as income on the W-2.

Qualifying Events and IRS Code Section 125

IRS Code Section 125

Premiums for medical and dental insurance, certain Aflac policies and contributions to Health Care FSA 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 employee pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Please Note: *Even though certain Aflac policies, including Aflac Short-Term Disability, Aflac Life (Term and Whole Life) are deducted post-tax, cancellation of any Aflac policy(s) must be done during Open Enrollment.*

Under certain circumstances, employees may be permitted to make changes to benefit elections during the plan year, if the event affects the employee, spouse and/or 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 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)
- Employee, employee's spouse or dependent(s) terminate or start 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 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 NOTES

If an employee **experiences a qualifying event**, the employee must log into **BenTek within 30 days of the qualifying event** to make the appropriate changes to 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 dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take effect on the first of the month following the qualifying event, with the exception of newborns which are effective on the date of birth. Cancellation of coverage will be effective on the last day of the month, unless termination is due to death. In the event of death, coverage will terminate on the date following the death. Employees will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for each medical plan is provided as a supplement to this booklet being distributed to new hires and existing employees during open enrollment. These summaries are 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 and Risk Management Dept.
Address:	4800 West Copans Rd. Coconut Creek, FL 33063
Phone:	(954) 973-6715
At Website URL:	www.mybentek.com/coconutcreek

The SBC is a summary of each plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Human Resources and Risk Management Department or online at the above website address.

If employees have any questions about the plan offerings or coverage options, please contact the Human Resources and Risk Management Department at (954) 973-6715.

Cigna OAPIN Plan At-A-Glance

Locate a Provider

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

Plan References

**LabCorp or Quest are the preferred labs for bloodwork through Cigna. When using labs other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.*

Important Notes

- *There is a separate $2,350/$4,700 per calendar year, pharmacy out-of-pocket limit, that does not accumulate towards the medical calendar year out-of-pocket limit.*
- *Services received by providers and facilities not in the Open Access Plus Network will be denied.*

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	$1,000
Family	$2,000
Coinsurance	
Member Responsibility	10%
Calendar Year Out-of-Pocket Limit	
Single	$4,000
Family	$8,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance and Medical Copays
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$30 Copay
Specialist Office Visit *(No Referral Required)*	$50 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Blood Work)*: LabCorp or Quest*	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	10%
Outpatient Surgery in Surgical Center	10% After CYD
Physician Services at Surgical Center	10% After CYD
Urgent Care *(Per Visit; Waived if Admitted)*	$75 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	10% After CYD
Physician Services at Hospital	10% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$200 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospitalization	10% After CYD
Outpatient Services	$50 Copay
Prescription Drugs *(Rx)*	
Calendar Year Out-of-Pocket Limit for Rx Costs	**Single:** $2,350 **Family:** $4,700
Tier 1	$15 Copay
Tier 2	$35 Copay
Tier 3	$60 Copay
Tier 4	$80 Copay
Mail Order Drug *(90 Day Supply)*	2x Retail Copay

Cigna OAP HDHP Plan At-A-Glance

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network****
Single	$2,600	$5,000
Family	$5,200	$10,000
Coinsurance		
Member Responsibility	0%	30%
Calendar Year Out-of-Pocket Limit		
Single	$5,000	$10,000
Family	$10,000	$20,000
What Applies to the Out-of-Pocket Limit?	Deductible (Medical and Rx Coinsurance) and Rx Copays	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	0% After CYD	30% After CYD
Specialist Office Visit *(No Referral Required)*	0% After CYD	30% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Blood Work)*: LabCorp or Quest*	0% After CYD	30% After CYD
X-rays	0% After CYD	30% After CYD
Advanced Imaging *(MRI, PET, CT)*	0% After CYD	30% After CYD
Outpatient Surgery in Surgical Center	0% After CYD	30% After CYD
Physician Services at Surgical Center	0% After CYD	30% After CYD
Urgent Care *(Per Visit; Waived if Admitted)*	0% After CYD	0% After In-Network CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	0% After CYD	30% After CYD
Physician Services at Hospital	0% After CYD	30% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	0% After CYD	0% After In-Network CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospitalization	0% After CYD	30% After CYD
Outpatient Services	0% After CYD	30% After CYD
Prescription Drugs *(Rx)*		
Tier 1	$15 Copay After CYD	30% After CYD
Tier 2	$35 Copay After CYD	30% After CYD
Tier 3	$60 Copay After CYD	30% After CYD
Tier 4	$80 Copay After CYD	30% After CYD
Mail Order Drug *(90 Day Supply)*	2x Retail Copay After CYD	Not Covered

Locate a Provider

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

Plan References

**LabCorp or Quest are the preferred labs for bloodwork through Cigna. When using labs other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.*

******Out-of-Network Balance Billing:*** *For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the plan's summary of benefits and coverage document.*

Important Notes

- *Once the calendar year deductible has been met, member pays $0 for eligible medical expenses; however, employee will be responsible for the Rx Copay, until the calendar year out-of-pocket limit has been met.*
- *Some services require pre-authorization. Failure to receive pre-authorization prior to receiving services may result in a 50% penalty.*

Cigna OAP Plan At-A-Glance *(Plan No Longer Offered)*

Locate a Provider

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

Plan References

**LabCorp or Quest are the preferred lab for bloodwork through Cigna. When using labs other than LabCorp or Quest, please be sure to confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.*

*****Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the plan's summary of benefits and coverage document.*

Important Notes

- *There is a separate $2,350 / $4,700 per calendar year, Pharmacy Out of Pocket Limit, that does not accumulate towards the Medical Calendar Year Out of Pocket Limit.*
- *Some services require pre-authorization. Failure to receive pre-authorization prior to receiving services may result in a 50% penalty.*

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network****
Single	$1,000	$4,000
Family	$2,000	$8,000
Coinsurance		
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Limit		
Single	$4,000	$6,000
Family	$8,000	$12,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance and Medical Copays	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$30 Copay	30% After CYD
Specialist Office Visit *(No Referral Required)*	$50 Copay	30% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Blood Work)*: LabCorp or Quest*	No Charge	30% After CYD
X-rays	No Charge	30% After CYD
Advanced Imaging *(MRI, PET, CT)*	10%	30% After CYD
Outpatient Surgery in Surgical Center	10% After CYD	30% After CYD
Physician Services at Surgical Center	10% After CYD	30% After CYD
Urgent Care *(Per Visit; Waived if Admitted)*	$75 Copay	$75 Copay
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After CYD	30% After CYD
Physician Services at Hospital	10% After CYD	30% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$200 Copay	$200 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospitalization	10% After CYD	30% After CYD
Outpatient Services	10% After CYD	30% After CYD
Prescription Drugs *(Rx)*		
Calendar Year Out-of-Pocket Limit for Rx Costs	**Single:** $2,350	**Family:** $4,700
Tier 1	$15 Copay	30%
Tier 2	$35 Copay	30%
Tier 3	$60 Copay	30%
Tier 4	$80 Copay	30%
Mail Order Drug *(90 Day Supply)*	2x Retail Copay	Not Covered

Health Savings Account

Employees who enroll in the OAP HDHP will have a Health Savings Account (HSA) opened with HSA Bank. Funds in the HSA are interest-bearing and may be used to offset a wide variety of health related costs incurred under the health plan that apply towards the employee's deductible or coinsurance.

- ✓ 2017 IRS Calendar Year Contribution Limitations: $3,400 (individual coverage); $6,750 (family coverage)
- ✓ 2018 IRS Calendar Year Contribution Limitations: $3,450 (individual coverage); $6,900 (family coverage)
- ✓ The HSA catch up contribution for individuals 55 and older remains $1,000

An HSA is an interest-bearing account an employee may elect to fund via pre-tax, evenly disbursed payroll deductions or a lump sum payroll deduction; this decision can be made and changed throughout the year by submitting an HSA change form, which can be found on Coconet. Employee contributions may also be made on an after-tax basis and taken as an above-the-line deduction on an employee's tax return (making such contributions tax-free). Guidelines regarding the HSAs are established by the IRS so employees should thoroughly review the enrollment materials before deciding to elect an HSA.

What you need to know about your HSA

- To be eligible to open or contribute to an HSA, an employee must be covered by a high deductible health plan.
- Employees may not be covered under another medical plan that is not a high deductible health plan including a plan in which a spouse has elected family coverage.
- HSA dollars can be used tax-free for all eligible IRS 213.d medical expenses.
- No "use-it or lose-it" rules such as in Flexible Spending Accounts; funds are in the account when needed, now or in the future.
- Participants cannot contribute to a traditional Health Care FSA, but may contribute to a Limited Purpose FSA for dental, vision and/or hearing expenses.
- HSA funds are portable from one employer to another.
- Domestic partners and over-age dependents are not able to use HSA funds for qualified expenses, even if covered under the medical plan, as federal law does not recognize them as a qualified dependent.
- Employee with adult children up to age 30 covered under the health insurance plan, may only use HSA funds for qualified expenses if the adult child is still a tax dependent.
- HSA funds earn interest.
- An account holder will receive two debit cards which will be issued to the member at no cost. Additional cards may be issued for a service fee.
- An account holder may request a checkbook for an additional fee per book of 25 checks. The account holder has the option of choosing a checkbook when they enroll via the web.
- The account holder may view balance and transactions on www.mycigna.com. The account holders may also request paper statements at a minimal cost. To avoid a monthly statement fee, employees may log into their HSA account and change to "online delivery method."
- Please refer to the HSA plan for additional information on services and changes.
- HSA funds may be used for eligible medical expenses for qualified tax dependents even if the dependent is not enrolled in the employee's group insurance benefits.
- **If an employee is enrolled in Medicare, TRICARE or TRICARE for Life, the employee is not eligible to contribute funds into an HSA.** If an employee is not enrolled in Medicare, TRICARE or TRICARE for Life, the employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts (noted above).
- Active employees NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse enrolled in Medicare may contribute the full family HSA contribution allowed by the IRS. These funds may be utilized for the active employee and spouse expenses.
- Active employees ON Medicare with a spouse NOT enrolled in Medicare: Active employee enrolled in Medicare and covering a spouse not enrolled in Medicare may NOT contribute to the HSA. Any remaining balance in the HSA may be utilized until there are no funds remaining.

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

Dental Insurance

Cigna Dental DHMO Plan

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

In-Network Benefits

The DHMO dental plan is an in-network only plan and **requires** all services to be provided by a Primary Dental Provider (PDP). Employee and dependent(s) may select any participating dentist in the Dental Care HMO network. There is no coverage for services received out-of-network.

The DHMO plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following page. Please refer to the plan's summary of coverage document for a detailed listing of charges and what is covered.

Out-of-Network Benefits

The DHMO plan does not provide benefits for services rendered by providers or facilities who do not participate in the Cigna Dental Care HMO Network (considered "out of network") or by an in-network provider not designated as the primary dental provider (unless referred by an employee's primary dental provider). Employee will pay out of pocket if they utilize any out-of-network providers.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Benefit Maximum

There is no benefit maximum.

IMPORTANT NOTES

- *Each covered employee and family member(s) may receive two (2) free cleanings per calendar year covered under the preventive benefit. Two additional cleanings are available at the charge of a copay ($50 for adults/$40 for children).*
- *Referrals and prior authorizations are required to see a specialist (oral surgeon, periodontist, orthodontist, etc.) within the network.*
- *Waiting periods and age limitations may apply for some services.*
- *Children under seven (7) may visit a pediatric dentist. Contact Cigna for a list of pediatric dentists in the network. Once the child reaches age seven (7), a referral with approved medical reasons by Cigna will be required prior to being seen by a pediatric dental provider.*
- *Coverage and age limitations may apply to some services. Check the plan summary or contact Cigna prior to having services rendered.*
- *The summary is provided as a convenient reference and additional charges may apply. For a full listing of covered services, exclusions, and stipulations, refer to the plan's Schedule of Benefits or contact Cigna's customer service for details specific to a procedure.*

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

Cigna Dental DHMO Plan At-A-Glance

Network	Dental Care HMO	
Calendar Year Deductible (CYD)	**In-Network Only**	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Calendar Year Benefit Maximum	**In-Network Only**	
Per Member	Does Not Apply	
Class I Services: Diagnostic & Preventive Care	**Code**	**In-Network**
Office Fee		$5 Copay
Routine Oral Exam *(2 Per Calendar Year)*	0150	$0 Copay
Routine Cleanings *(2 Per Calendar Year)*	1110/1120	$0 Copay
Bitewing X-rays *(2 Films)*	0272	$0 Copay
Complete X-rays *(1 Set Every 3 Years)*	0210	$0 Copay
Fluoride Treatments *(Children To Age 19; 2 Per Calendar Year)*	1203	$0 Copay
Sealants - *Per Tooth*	1351	$11 Copay
Space Maintainers	1510	$30 Copay
Emergency Care to Relieve Pain *(During Regular Hours)*	9110	$6 Copay
Class II Services: Basic Restorative Care		
Fillings *(Amalgam)*	2140	$0 Copay
Fillings *(Composite; Anterior)*	2330	$0 Copay
Fillings *(Composite; Posterior - 3 Surfaces)*	2393	$85 Copay
Simple Extractions	7140	$6 Copay
Surgical Extractions *(Soft Tissue)*	7220	$55 Copay
Root Canal Therapy* *(Excluding Final Restoration)*	3330	$275 Copay
Periodontal Maintenance *(4 Per Calendar Year; Per Visit)*	4910	$35 Copay
General Anesthesia *(First 30 Minutes)*	9220	$160 Copay
Repairs to Dentures*	5510	$35 Copay
Class III Services: Major Restorative		
Bridges*	5213/5214	$200 Copay
Crowns*	2752	$230 Copay
Dentures*	5110/5120	$185 Copay
Class IV Services: Orthodontia		
Lifetime Maximum	Not Available	None
Benefit — Child* *(Up to 19th Birthday)*	8670	$1,460 Copay
Benefit — Adult*	8670	$2,160 Copay

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Cigna Dental Care HMO network.

Plan References

** Additional charges may apply for some services. Please see your plan summary or contact Cigna's Customer Service for details specific to your procedure.*

Dental Insurance

Cigna Dental PPO Plan

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

In-Network Benefits

The PPO plan provides benefits for services received from in-network and out-of-network providers. It is an open access plan and 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 Cigna Advantage network. Employee will save money by utilizing a dental provider in this network. The participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and coinsurance based on the plan's charge limitations.

Please Note: *Services received from a Cigna DPPO dental provider are paid at the out-of-network benefit level. However, members cannot be billed for more than the provider's contracted rates with Cigna, so they are protected from out-of-network balance billing.*

Out-of-Network Benefits

Out-of-network benefits are used when members receive services from a Cigna DPPO provider or a non-participating provider. Cigna 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 Cigna reimburses (MRC) for such services and the amount charged by the dentist. This is known as balance billing (does not apply for out-of-network Cigna DPPO providers). Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The dental PPO plan requires a $50 individual and 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 $2,000 and the member will be responsible for all future charges until the next calendar year for in-network or out-of-network services combined. All services, including preventive services, accumulate towards the benefit maximum.

IMPORTANT NOTES

- *Each covered employee and family member(s) may receive two (2) free cleanings per calendar year covered under the preventive benefit. Additional cleanings are available at the charge of a copay.*
- *Late entrant provisions, age limitations and waiting periods may apply.*
- *A pre-treatment review is recommended when dental services are expected to exceed $200. Members must request their dentist submit the pre-treatment review to Cigna since it is recommended and not required.*
- *Teeth missing prior to coverage under the Cigna Dental plan are not covered.*
- *The summary is provided as a convenient reference and additional charges may apply. For a full listing of covered services, exclusions, and stipulations, refer to the plan's Schedule of Benefits or contact Cigna's customer service for details specific to a procedure.*

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

Cigna Dental PPO Advantage Plan At-A-Glance

Network	Cigna DPPO Advantage	Cigna DPPO	Out-of-Network*
Calendar Year Deductible (CYD)			
Per Member	$50	$100	$100
Per Family	$150	$300	$300
Waived for Class I Services?	Yes		
Calendar Year Benefit Maximum			
Per Member	$2,000		
Class I Services: Diagnostic & Preventive Care			
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Calendar Year)*			
Bitewing X-rays *(2 Per Calendar Year)*			
Complete X-rays *(1 Set Every 3 Calendar Years)*			
Emergency Care to Relieve Pain			
Class II Services: Basic Restorative Care			
Fillings	Plan Pays: 100% After CYD	Plan Pays: 80% Deductible Waived	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions			
Endodontics *(Root Canal Therapy)*			
Oral Surgery			
Periodontal Services			
Anesthetics			
Class III Services: Major Restorative Care			
Crowns	Plan Pays: 60% After CYD	Plan Pays: 50% Deductible Waived	Plan Pays: 50% *(Subject to Balance Billing)*
Dentures			
Bridges			

How Do You Use the Cigna DPPO Plan?

- The plan provides in-network coverage for services received from Cigna DPPO Advantage dentists. Cigna DPPO Advantage services are available at the highest discount when compared to Cigna DPPO dentists and non-participating dentists.
- Services received from Cigna DPPO dentists are paid at the out-of-network benefit level. However, members cannot be billed for more than the provider's contracted rates with Cigna, so they are protected from out-of-network balance billing.
- Out-of-network coverage is also still provided for all non-participating dentists at the out-of-network benefit level, but balance billing will apply.

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Cigna Dental PPO or EPO 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 for services rendered, please refer to the Out-of-Network Benefits section on the previous page.*

Flexible Spending Account

The City offers Flexible Spending Accounts (FSA) administered through Chard-Snyder. The FSA plan year is from October 1 to September 30; however, the annual maximum is based upon the calendar year.

If an employee or family member(s) has predictable health care or work-related day care expenses, then the employee 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 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 qualified medical and/or dependent care 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:

Health Care FSA

This account allows participants to set aside up to a calendar year maximum of $2,500. 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 the participating employee is single or married and files a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and adults.

Please note, 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.

The City offers: Health Care FSA, Limited Purpose FSA, and Dependent Care FSA

- **Health Care FSA:** This is available to eligible employees who are not enrolled in the OAP HDHP. The Health Care FSA covers medical, dental, and vision expenses not paid by insurance.
- **Limited Purpose FSA:** This is available to eligible employee who are enrolled in the OAP HDHP. A Limited Purpose Health FSA may be used for qualified dental, vision and hearing expenses.
- **The Dependent Care FSA:** This covers day care expenses for qualified dependent(s) that are necessary for the employee and legal spouse, if married, to work.

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

- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental Fees/Orthodontic Fees*
- ✓ Diagnostic Tests/Health Screenings*
- ✓ Doctor Fees
- ✓ Drug Addiction/Alcoholism Treatment*
- ✓ Experimental Medical Treatment
- ✓ Eyeglasses/Contact Lenses (Corrective)*
- ✓ Hearing Aids and Exams*
- ✓ Injections and Vaccinations*
- ✓ Lasik Surgery*
- ✓ Mental Healthcare
- ✓ Nursing Services
- ✓ Optometrist Fees*
- ✓ Physician Office Visits
- ✓ Prescription Drugs
- ✓ Medically Necessary Sunscreen
- ✓ Wheelchairs

**These items are eligible expenses under the Limited Purpose FSA*

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

Flexible Spending Account *(Continued)*

FSA Guidelines

- Any unused funds, after a plan year/grace period ends and all claims filed, cannot be returned to an employee or carried forward to the next plan year.
- Reimbursement on eligible expenses incurred during the period of coverage within the plan year October 1 through September 30.
- The Health Care FSA has a grace period at the end of the plan year (September 30) to submit reimbursement for eligible expenses incurred through December 15.
- Employee can enroll in either or both of the FSAs only during the open enrollment period, a qualifying event, or new hire eligibility.
- Funds cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependents cannot be reimbursed for services they have not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses which are reimbursed through an FSA.

Filing a Claim

Claim Form

With the Benny® prepaid benefits card, employee can pay for many expenses without cash. If an employee does pay out-of-pocket for the claim, reimbursement claims can be submitted by mail, fax, email, through the website at www.chard-snyder.com or with the mobile app can be downloaded from the Chard Snyder website under the Support Center tab. 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. Chard Snyder may request supporting documents for expenses paid with a debit card. Failure to provide supporting documents when requested, may result in suspension of the card and account until funds are substantiated or refunded back to Chard Snyder. This card will not expire at the end of the benefit year. Please keep the issued card for use next year.

HERE'S HOW IT WORKS!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $38.46 based on a 26 pay period schedule. As a result, 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 any unused funds remaining in employee's FSA after a plan year ends and after all claims have been filed cannot be returned or carried forward to the next plan year. This rule is known as "use it or lose it."

Chard-Snyder | Customer Service: (800) 982-7715 | www.chard-snyder.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides a Basic Term Life insurance benefit through Unum to all eligible full-time employees. All benefit-eligible employees will receive a benefit amount of $20,000.

The Basic Term Life insurance coverage amount reduces to 65% at age 70 and 50% at age 75.

Accidental Death & Dismemberment

The City offers Accidental Death & Dismemberment (AD&D) insurance at no cost to eligible full-time employees. This benefit 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.

The AD&D coverage amount reduces to 65% at age 70 and 50% at age 75.

Voluntary Employee Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

Eligible employees may elect to purchase additional Life and AD&D insurance through Unum. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages. Voluntary Life and AD&D insurance offers coverage for the employee, spouse and/or child(ren) at different benefit levels.

A new hire may purchase voluntary employee life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $130,000.**

During Open Enrollment, employees enrolled in Voluntary Employee Life insurance may be able to increase their coverage up to the Guaranteed Issue amount of $130,000 without Evidence of Insurability.

- Units can be purchased in increments of $10,000 to a maximum of 5 times salary or $500,000, whichever is less.
- Benefit amounts reduce to 65% of the original amount at age 70 and 50% of the original amount at age 75.
- Accidental Death & Dismemberment (AD&D) insurance is included.

Voluntary Spouse Life and AD&D Insurance

Voluntary Spouse Life and AD&D Insurance

A new hire can purchase voluntary spouse life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $130,000.**

During Open Enrollment, employees enrolled in Voluntary Spouse Life insurance may be able to increase their coverage up to the Guaranteed Issue amount of $130,000 without Evidence of Insurability.

- Employees must participate in voluntary Employee Life and AD&D coverage in order to elect voluntary Spouse Life and AD&D coverage.
- Coverage can be purchased in increments of $10,000 not to exceed $500,000 or the employee's voluntary Life Coverage amount.
- Benefit amounts reduce to 65% of the original amount at age 70 and 50% of the original amount at age 75 based on the employees age, not the covered spouse's age.
- Accidental Death & Dismemberment (AD&D) insurance is included.

Voluntary Child Life Insurance Only

- Employee must participate in voluntary Employee Life and AD&D in order to elect voluntary Child Life insurance.
- Units of coverage may be purchased for dependent children as follows:
  - Child(ren) ages live birth to age six (6) months $1,000.
  - Child(ren) ages six (6) months to age 19 (26 if a full-time student) $10,000.
  - Coverage is $0.12 Per Pay Period for all eligible child(ren) enrolled.

Always remember to keep beneficiary forms updated. Employees may update beneficiary information at anytime through BenTek.

Unum | Customer Service: (800) 421-0344 | www.unum.com

Long Term Care Insurance

Long Term Care is the assistance received when someone needs help with two or more Activities of Daily Living – such as dressing, bathing, going to the bathroom, eating or moving about – or when someone suffers a severe cognitive impairment. This care could be provided in the home, in an assisted living or residential care facility, or in a skilled nursing facility such as a nursing home.

The City offers coverage in the form of a fixed dollar indemnity benefit if an employee becomes disabled. Coverage is subject to policy limitations, benefit maximums and elimination periods.

Benefit Duration	3 Years	6 Years
Facility Benefit Amount Per $1,000 Increments	$1,000 to $6,000	$1,000 to $6,000
Assisted Living Facility Percent	60%	60%
Lifetime Maximum Per $1,000 Increments	$36,000	$72,000
Professional Home Care	50%	50%
Total Home Care — Option	50%	50%

Unum | Customer Service: (866) 679-3054 | www.unum.com

Short Term Disability

The City provides Short Term Disability (STD) insurance at no cost to all eligible full-time employees through Unum. The STD plan pays the employee a percentage of their weekly earnings if they become disabled due to an illness or non-work related injury.

Short Term Disability (STD) Benefits

- The STD plan offers a benefit of 70% of an employee weekly earnings, up to a benefit maximum of $1,250 per week.
- Employee must be disabled or ill for 14 days prior to becoming eligible for benefits (known as the elimination period).
- The maximum benefit period is 24 weeks (Does not include the elimination period).
- Benefits may be reduced by other income.

Unum | Customer Service: (800) 421-0344 | www.unum.com

Long Term Disability

The City provides Long Term Disability (LTD) insurance through Unum at no cost to all eligible full-time employees. The LTD plan pays the employee a percentage of their monthly earnings if they become disabled due to an illness or non-work related injury.

Long Term Disability (LTD) Benefits

- The LTD plan offers a benefit of 66.67% of an employee's monthly earnings, up to a benefit maximum of $5,000 per month.
- An employee must be disabled for 180 days/26 weeks prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will commence on the 181st day of disability.
- An employee may continue to be eligible for benefits if they return to work on a part-time basis.
- Benefits may be reduced by other income.
- Benefits may be paid to the employee up to their social security normal retirement age (depending on a number of factors). See plan document or contact Unum for additional information.

Unum | Customer Service: (800) 421-0344 | www.unum.com

Employee Assistance Program

The City cares about employee's well-being on and off the job and provides all eligible employees and family/household members an Employee Assistance Program (EAP) through Cigna at no cost.

What is an Employee Assistance Program?

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

- ✓ Stress Management
- ✓ Parenting Problems
- ✓ Marital Problems
- ✓ Relationship Issues
- ✓ Substance Abuse
- ✓ Critical Incident Debriefing
- ✓ Child Care
- ✓ Elder Care
- ✓ Financial Services

How Do Employees Access EAP Benefits?

The EAP provides up to six (6) face-to-face counseling sessions per occurrence for short-term problem resolution. Conditions that require long-term treatment may be referred to your medical plan. The EAP also provides unlimited phone consultation with an EAP professional available 24 hours a day, seven (7) days a week. Contact customer service at (877) 622-4327.

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or 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 case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Cigna | Customer Service: (877) 622-4327 | www.cignabehavioral.com
Employee ID: coconutcreek

Supplemental Insurance

Aflac offers a variety of supplemental insurance plans that may be purchased separately on a voluntary basis. Premiums are paid via payroll deduction. Aflac pays cash directly to the employee, regardless of what other insurance plans employee may have. Coverage is available for employee, spouse and children on most plans. The coverage is portable when the employee retires or changes jobs, with no increase in premiums. To learn more about these plans and/or to schedule a personal appointment, contact KCI Financial Services. Details regarding the following available plans and services are available online at kcifinancialservices.com.

- ✓ Aflac Life, Term and Whole Life
- ✓ Critical Care and Recovery *(Plan 2)*
- ✓ Hospital Advantage
- ✓ Cancer Care *(Classic, Select, Preferred and Premier)*
- ✓ Short Term Disability Insurance *(Guarantee Issue)*
- ✓ Accident Indemnity Advantage - 24 Hour Protection

Claims Mailing Address | PO Box 49347, Sarasota, FL 34230
Claims Email: claims@kcifinancialservices.com

Aflac | Local Agent: KCI Financial Services
Local Office: (954) 443-4443
Email: lcohen@kcifinancialservices.com & ccohen@kcifinancialservices.com

Legal Plan and IDShield

The City offers employees the opportunity to participate in a Legal or IDShield plan provided by LegalShield. The IDShield plan protects employees, their spouse and child(ren) by giving them access to one of the world's leading risk management companies, Kroll Advisory Solutions. Kroll can assist with identity theft consultations, credit report with analysis, credit monitoring and full restoration of benefits should an employee or a covered family member become a victim of Identity Theft.

By enrolling in the Legal Plan, employee will have Nationwide access to a network of law firms who are pre-paid and ready to provide for advice on unlimited issues, plus legal help for a variety of situations that include*:

- ✓ Wills & Living Wills
- ✓ Healthcare Directive
- ✓ Letters & Phone Calls
- ✓ Contract Review
- ✓ Real Estate
- ✓ Traffic Tickets
- ✓ Family Law
- ✓ Child Custody
- ✓ Civil Litigation
- ✓ Bankruptcy
- ✓ Adoption
- ✓ IRS Audits

	Individual	Family
LegalShield	$7.27	$7.27
IDShield	$4.13	$8.75
Legal & IDShield	$11.40	$14.17

See brochure for complete coverage details (including dependent eligibility information).

Please Note: *Employee currently enrolled in the Identity Theft Plan have the option to upgrade to IDShield or keep the plan they have at the same rate they are currently paying.*

Agent: Don Thompson
Phone: (239) 549-4746| Email: donthompson@legalshieldassociate.com

LegalShield | Legal & IDShield Plans
Customer Service: (800) 654-7757 | www.legalshield.com

Employee Wellness Committee

The City has a genuine interest in health, nutrition and overall well being of the employees! We offer wellness programs and various events to benefit employee wellness throughout the year. We welcome new ideas and are actively seeking employee participation and assistance with the City Wellness initiative. Keep an eye out for the next wellness event/program, and be a participant.

Please see the Human Resources and Risk Management Department for more information.

Notes

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

Employee Claims Resource

Do you have a question about how a claim was paid?

Are you receiving bills from your provider and not understanding why?

Do you want a better understanding of how your benefits work?

The Gehring Group has a team of claims specialists to assist you with these concerns.

You can contact a claims specialist in one of the following ways:

1. Email: coconutcreek@gehringgroup.com

Be sure to include your name, a brief description of your concern, and your contact information. A Gehring Group Claims Specialist will contact you via a secure email or phone call to gather additional information that may be necessary to further assist you.

OR

2. Call: (800) 244-3696

Be sure to identify yourself as an employee of the City of Coconut Creek and ask to speak to a Claims Specialist. You will be immediately directed to a Gehring Group Claims Specialist who will be more than happy to assist you.

Office hours are Monday through Friday from 8:30am – 5:00pm. If you should call after office hours please leave a message indicating that you are a City of Coconut Creek employee and would like to speak to a Claims Specialist. Be sure to leave your phone number in the message and a Claims Specialist will contact you within the next business day.

Our goal is to ensure issues are resolved as quickly as possible, as we sympathize and understand the hardship this may cause some employees.

Notes

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

Notes

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

DRAFT 4

City of Coconut Creek Florida

GEHRING GROUP
EMPLOYEE BENEFITS | RISK MANAGEMENT

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www.gehringgroup.com

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