

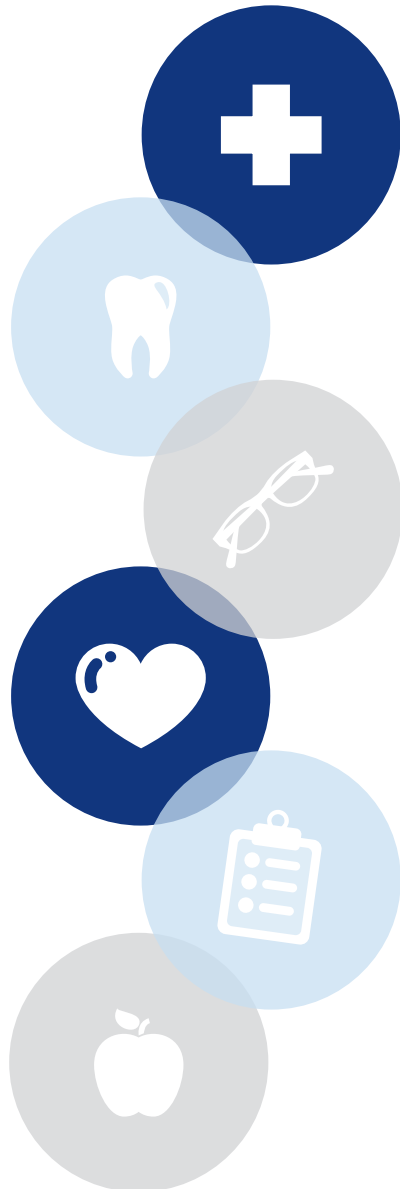


2025 | 2026
EMPLOYEE BENEFIT HIGHLIGHTS



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This booklet is merely a summary of 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 Village of Royal Palm Beach reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.



Contact Information

	Human Resources	Human Resources	Phone: (561) 790-5120
	Payroll/Benefits	Payroll/Benefits Department	Phone: (561) 790-5117
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) app.mybentek.com/royalpalmbeach
	Medical Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Cigna/Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
	Health Savings Account	HSABank	Customer Service: (800) 357-6246 www.hsabank.com
	Health Reimbursement Account	HSABank	Customer Service: (800) 357-6246 www.hsabank.com
	Dental Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	Cigna Healthcare Serviced by EyeMed	Customer Service: (888) 353-2653 www.mycigna.com
	Flexible Spending Accounts	HSABank	Customer Service: (800) 357-6246 www.hsabank.com
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Voluntary Life Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Short Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Long Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Employee Assistance Program	Aetna Resources for Living	Customer Service: (888) 238-6232 www.resourcesforliving.com Username: MYRPBEAP Password: EAP
		Teladoc	Agent: Abby Woll Phone: (860) 217-0851 ext 104 Customer Service: (800) 835-2362 www.teladoc.com
		Aflac	Agent: Katty Cohen Phone: (561) 414-0032 Customer Service: (800) 992-3522 www.aflac.com
	Supplemental Insurance	LegalShield	Agent: Barry Olfern Phone: (954) 655-2446 Customer Service: (800) 654-7757 https://shieldbenefits.com/royalpalmbeach/overview
		Washington National	Agent: Tucker Doucette Phone: (727) 251-0603 Customer Service: (800) 525-7662 www.washingtonnational.com
		FRS	Pension Customer Service: (844) 377-1888 www.frs.myflorida.com Investment/Financial Guidance: (866) 446-9377 www.myfrs.com
	Retirement Plans	MissionSquare Retirement (ICMA)	Agent: Steven Feigelis Cell: (202) 759-7058 Customer Service: (800) 669-7400 www.missionsq.org
		Empower (Prudential)	Agent: Richard R. Fulton Cell: (561) 670-5501
		Corebridge Financial Retirement Services (VALIC)	Agent: Tony Tringali Office: (561) 684-3775 Cell: (772) 521-2007



Introduction

The Village of Royal Palm Beach provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the Village of Royal Palm Beach'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 Payroll/Benefits or Human Resources for further information.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided as a supplement to this booklet which is being distributed to new hires and existing employees during the Open Enrollment Period. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	Payroll/Benefits or Human Resources
Address:	1050 Royal Palm Beach Blvd. Royal Palm Beach, FL 33411
Phone:	(561) 790-5120 (561) 790-5117
Website:	www.royalpalmbeachfl.gov

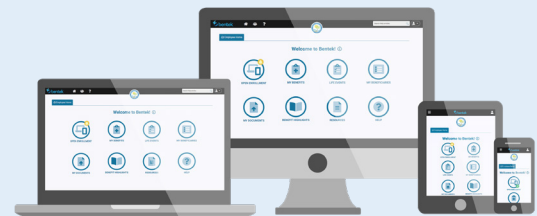
The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting Payroll/Benefits or Human Resources.

If there are any questions about the plan offerings or coverage options, please contact Payroll/Benefits or Human Resources (561) 790-5120 or (561) 790-5117.

Online Benefit Enrollment

The Village provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Events.

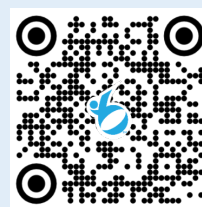
Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report qualifying events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

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

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



To access Bentek using a mobile device, scan code.



Group Insurance Eligibility



The Village's group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the Village's insurance plans if they are full-time employees working a minimum of 40 hours per week. Employees who work less than 40 hours per week may be eligible for medical coverage under the Affordable Care Act, if they meet certain requirements. Coverage will be effective the first day of the month following 30 days of employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 1.

Separation of Employment

If employee separates employment from the Village, insurance for medical, dental and vision will continue through the end of the month in which the separation occurred. Other coverage may terminate on the last date of employment. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse 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 State Statute)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent (taxable dependent) may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

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

Dental and Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 30.

Disabled Dependents

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

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

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

Taxable Dependents

Employee covering adult child(ren) under employee's medical, dental and vision insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, imputed income must be reported on the employee's W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare taxes. Imputed income is the dollar value of insurance coverage attributable to covering each adult dependent child. Contact Payroll/Benefits or Human Resources for further details if covering an adult dependent child who will turn age 27 any time during the upcoming calendar year or for more information.

***Please Note:** There is no imputed income if adult dependent child is eligible to be claimed as a dependent for Federal income tax purposes on the employee's tax return.*



Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Flexible Spending Accounts (FSA), and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made **ONLY** during the Open Enrollment Period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)



IMPORTANT NOTES

If employee experiences a Qualifying Event, **Payroll/Benefits or Human Resources 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 Village offers medical insurance through Cigna Healthcare 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 Cigna's customer service.

Medical Insurance – Cigna HDHP Open Access Plus Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$52.49
Employee + Spouse	\$190.95
Employee + Child(ren)	\$173.42
Employee + Family	\$292.28

The Village subsidizes a portion of employees' insurance premium for certain group coverages explained in this booklet based on the following schedule:

Medical Insurance: 90% of the premium for single coverage and 80% for all other tiers for the Cigna Healthcare Medical Plan

Dental Insurance: 80% of the premium for the Cigna Healthcare DHMO Plan

In addition, the Village provides a rebate to benefit-eligible employees who waive all coverages, only cover themselves, or elect dental insurance only. A premium schedule may be obtained from Payroll/Benefits or Human Resources.

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

Medical Plan Resources

Cigna offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other medical plan resources, please contact Cigna's customer service at (800) 244-6224 or visit www.mycigna.com.

24 Hour Help Information Hotline (800) CIGNA-24

The Cigna 24-Hour Health Information Line provides access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do when a child 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 member weigh the risks and advantages of treatment options. The call is free and is strictly confidential.

Cigna One Guide

Cigna One Guide service can help members make smarter, informed choices and get the most from the medical plan. It is Cigna's highest level of support that combines the ease of a powerful app with the personal touch of live service. One Guide personal support, tools and reminders can help you stay healthy and save money. With Cigna One Guide members can:

- ✓ Understand plan coverage and how it works
- ✓ Get answers to health care or plan questions
- ✓ Find an in-network doctor, lab or urgent care center
- ✓ Connect to health coaches, pharmacists and more
- ✓ Stay on track with appointments and preventive care
- ✓ Take advantage of dedicated one-on-one support for complex health situations
- ✓ Get cost estimates and service comparisons to avoid surprises

To speak with a personal guide download the myCigna app or contact (800) Cigna-24.

Mobile App

Mobile app provides on-the-go access to the medical benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Locate a Provider
- Download Member ID Cards
- View Claims

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. Member can log on to www.mycigna.com and select Wellness to learn more about these programs or contact (800) 870-3470.

- ✓ Nutritional meal delivery service
- ✓ Fitness memberships and devices
- ✓ Vision care and Lasik surgery
- ✓ Alternative medicine
- ✓ Hearing Care
- ✓ Yoga products and virtual workouts

IdentityForce

Cigna Healthcare provides employees enrolled in the Cigna HDHP Open Access Plus Health plan an identity theft protection plan through IdentityForce. This plan protects employees and their dependents up to age 18, against identity theft compromises and includes, but is not limited to the following benefits:

- ✓ 24/7 Monitoring (Social Security, Social Media, Dark Web, Financial Accounts, Password Manger)
- ✓ Sex Offender Notification
- ✓ Medical ID Fraud Protection
- ✓ Fully Managed Restoration Services
- ✓ \$1 Million Dollar Identity Theft Insurance Policy

To learn more about this plan or to sign up, contact IdentityForce's customer service at (833) 580-2523 or visit cigna.identityforce.com/starthere.



Cigna HDHP Open Access Plus Plan At-A-Glance

Network	Open Access Plus	
Plan Year Deductible (PYD) October 1 to September 30	In-Network	Out-of-Network*
Single	\$2,000	\$4,000
Family**	\$4,000	\$8,000
Coinsurance		
Member Responsibility	20%	40%
Plan Year Out-of-Pocket Limit		
Single	\$3,000	\$6,000
Family**	\$6,000	\$12,000
What Applies to the Out-of-Pocket Limit?	Deductibles, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician (PCP) Office Visit	20% After PYD	40% After PYD
Specialist Office Visit (No Referral Required)	20% After PYD	40% After PYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab (Bloodwork)***	20% After PYD	40% After PYD
X-rays	20% After PYD	40% After PYD
Advanced Imaging (MRI, PET, CT)	20% After PYD	40% After PYD†
Outpatient Surgery at Surgical Center	20% After PYD	40% After PYD
Physician Services at Surgical Center	20% After PYD	40% After PYD
Urgent Care (Per Visit)	20% After PYD	20% After PYD
Hospital Services		
Inpatient Hospital (Per Admission)	20% After PYD	40% After PYD
Outpatient Hospital (Per Admission)	20% After PYD	40% After PYD
Physician Services at Hospital	20% After PYD	40% After PYD
Emergency Room (Per Visit)	20% After PYD	20% After INN PYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services (Per Admission)	20% After PYD	40% After PYD
Outpatient Services (Per Visit)	20% After PYD	40% After PYD
Outpatient Office Visit	20% After PYD	40% After PYD
Prescription Drugs (Rx)		
Generic	\$10 Copay After PYD	20% After PYD
Preferred Brand Name	\$40 Copay After PYD	
Non-Preferred Brand Name	\$70 Copay After PYD	
Mail Order Drug (90-Day Supply)	2.5x Copay After PYD	



Locate a Provider

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



Plan References

***Out-of-Network Balance Billing:**
For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.

****Individual deductible and out-of-pocket limit does not apply if enrolled in the family plan.**

*****LabCorp and Quest 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.**

†Covered at in-network rate for emergency room and urgent care.



Health Savings Account

Cigna's High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollees to open a Health Savings Account (HSA). An HSA is an interest-bearing account where funds may be used to help pay employee and dependent(s) deductibles, coinsurance and any qualified healthcare expenses not covered by the plan.

2025-2026 Funding*

The Village will fund 2/3 of the annual Out-of-Pocket Maximum for the plan year between October 1 - September 30: \$2,000 for employee with single coverage or \$4,000 for employee with family coverage.

Employee may opt to fund an HSA via pre-tax evenly dispersed payroll deductions, or in a lump-sum payroll deduction. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free).

- **2025 IRS Contribution Limitations:**
\$4,300 (individual coverage) \$8,550 (family coverage)
- **2026 IRS Contribution Limitations:**
\$4,400 (individual coverage) \$8,750 (family coverage)
- Individuals age 55 and older can also make additional "catch-up" contributions up to \$1,000 annually.

This maximum HSA amount would include any employer and employee contributions (pre-tax or post-tax). If employee is receiving an employer contribution, employee will want to account for this towards the annual IRS total maximum so employee does not over-contribute for the tax year. Guidelines regarding the HSA are established by the IRS.

**Please contact Payroll Benefits or Human Resources for further information regarding funding variations towards employer HSA contributions.*

What to Know About an HSA

- Employee owns the HSA funds from day one and decides how and when to spend the money.
- No use-it-or-lose-it rules; funds are in the account when needed, now or in the future. Participant cannot fund a traditional Health Care FSA, however, participant may fund a Limited Purpose FSA for dental and vision expenses only.
- HSA funds may earn interest.
- The HSA will be partially funded with employer contributions. If employee desires to fund the remaining deductible balance they may do so with pre-tax payroll deductions.
- HSA dollars may be used tax-free for all eligible health care expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employee plan for retirement.
- An account holder may write a check or withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.

- Account holder can access HSA statement at any time to track account balance and activity online at www.hsabank.com.
- To be eligible to open an HSA, employee must be covered by a qualified high deductible health plan. Employee may not be covered under another medical plan that is not a high deductible health plan including a plan the employee's spouse may have selected where he/she has family coverage. **Please Note:** Eligibility status to qualify for an HSA is specifically driven by employee and NOT dependents.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Over-age dependent is not able to use HSA funds for qualified expenses, even if dependent is covered under the medical plan as Federal law does not recognize them as a qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits the Village from contributing HSA funds into the account. If employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the maximum contribution amount of tier enrolled..
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare is eligible to enroll and contribute into the HSA up to the maximum contribution amount tier enrolled. These funds can be utilized for the active employee and spouse expenses.
- Active employee ON Medicare and with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse may not contribute or receive HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

Mobile App

Mobile app provides on-the-go access to the HSA benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- File a Claim
- View Account Activity
- View Item for Eligibility
- Upload Receipts

HSABank | Customer Service: (800) 357-6246 | www.hsabank.com

Health Reimbursement Account

The Village provides employees a Health Reimbursement Account (HRA) beginning the month in which they reach age 65. Employee will receive a debit card to access these funds. The HRA amounts are pro-rated for new hires becoming eligible for the Village's employee benefits program outside of the annual Open Enrollment Period. The HRA is administered by HSABank. The HRA allocations are not taxable to the employee and can be used to offset the cost of a wide variety of health related expenses incurred under the medical, dental, or vision insurance plans. Examples of these expenses include copays for physician office visits, inpatient hospital stays, prescription drugs and other expenses that generate an out of pocket cost to the employee.

2025-2026 Funding

The Village will fund 2/3 of the annual Out-of-Pocket Maximum for the plan year between October 1 - September 30: \$2,000 for employee with single coverage or \$4,000 for employee with family coverage.

If an employee has an HRA and also elects a Limited Purpose FSA, FSA monies will be used first for dental and vision expenses, as it is employee-funded and does not rollover from year to year with the exception of the \$660 carry over. Please refer to pages 15 and 16 for more information.

Retain Receipts

During the year, employee should keep all receipts and documentation for prescriptions and medical related expenses if needed to verify a claim for HSABank 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 are available anytime online at www.hsabank.com or by calling HSABank at (800) 357-6246.

What happens to unused HRA funds at the end of the plan year?

Any remaining balance in an HRA at the end of the plan year will roll forward for the participant's use in the following years. However, upon discontinuation of participation, separation of employment or retirement from the Village, employee may continue to be an HRA participant for one (1) year. The funds available for reimbursement will be the amount in the HRA at time of separation, or upon discontinuation. After the following year, any remaining funds left in the HRA account will be returned to the Village.

File a Claim

Debit Card

Each employee will be provided with a debit card to use for payment of out-of-pocket medical expenses. This may prevent the employee from having to pay an expense first and then seek reimbursement. However, employees may be required to submit documentation of any expenses that do not match a charge associated with a specific service under the HDHP Open Access Plus Plan.

Claim Form

Employee may submit claim forms to HSABank and must include a copy of the carrier's Explanation of Benefits or receipts for eligible medical services received. Claim forms can be submitted via mail to HSABank. The form can be found at www.hsabank.com.

Mobile App

Mobile app provides on-the-go access to the HRA benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- File a Claim
- View Account Activity
- View Item for Eligibility
- Upload Receipts

Claims Mailing Address

HSABank | PO Box 939, Sheboygan, WI 53082

All claims must be filed within 90 days 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.

HSABank | Customer Service: (800) 357-6246 | www.hsabank.com



Dental Insurance

Cigna Dental Care DHMO (FAOV9) Plan

The Village offers dental insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Cigna's customer service.

Dental Insurance – Cigna Dental Care DHMO (FAOV9) Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$2.18
Employee + One	\$4.31
Employee + Family	\$6.46

In-Network Benefits

The DHMO plan is an in-network only plan that requires all services be received by a Primary Dental Provider (PDP). Employee and dependent(s) may select any participating dentist in the Cigna Dental Care Access 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 summary plan document for a detailed listing of charges and benefits.

Out-of-Network Benefits

The DHMO plan does not cover any services rendered by out-of-network facilities or providers.

Plan Year Deductible

There is no plan year deductible.

Plan Year Benefit Maximum

There is no benefit maximum.

Mobile App

Mobile app provides on-the-go access to the dental benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Locate a Provider
- Download Member ID Cards
- View Claims

IMPORTANT NOTES



- This dental plan runs on a plan year October 1 through September 30.
- Two (2) routine cleanings per plan year. Members can also receive two (2) additional cleanings at the charge of a copay.
- Referrals and prior authorizations are required to see specialists (Oral Surgeon and Periodontist) within the network.
- A referral is not required to see an in-network Orthodontist, Pediatric Dentist or Endodontist.
- Waiting periods and age limitations may apply.
- Children under age 13 may visit a pediatric dentist. Contact Cigna's customer service for a list of pediatric dentists in the network. Once the child reaches age 13, a referral with approved medical reasons will be required by Cigna prior to being seen by a pediatric dental provider.
- There is no age limit on sealants.
- A \$5 office visit copay may apply in addition to the service code charged.

Cigna Healthcare

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



Cigna Dental Care DHMO (FAOV9) Plan At-A-Glance

Network		Dental Care Access	
Plan Year Deductible (PYD) October 1 to September 30		In-Network Only	
Per Member		Unlimited	
Per Family			
Waived for Class I Services?			
Plan Year Benefit Maximum		In-Network Only	
Per Member		Unlimited	
Class I Services: Diagnostic & Preventive Care	Code	In-Network	
Office Visit	N/A	\$5 Copay	
Oral Evaluation	0120	No Charge	
Routine Cleanings (2 Per Calendar Year)	1110/1120	No Charge	
Bitewing X-rays (2 Per Calendar Year)	0272	No Charge	
Complete X-rays (1 Set Every 3 Years)	0210	No Charge	
Fluoride Treatments (2 Per Calendar Year)	1206	No Charge	
Sealants (Per Tooth)	1351	No Charge	
Class II Services: Basic Restorative Care			
Fillings (Amalgam; 1 Surface: Primary or Permanent)	2140	No Charge	
Fillings (Composite; 1 Surface: Anterior)	2330	No Charge	
Deep Cleaning	4355	\$86 Copay	
Periodontal Scaling (4 Quadrants Per Consecutive 12 Months)	4341	\$96 Copay	
Simple Extractions (Erupted/Exposed Tooth)	7140	\$12 Copay	
Surgical Removal of Tooth (Erupted/Impacted)	7210/7240	\$21/120 Copay	
Root Canal Therapy (Molar)*	3330	\$280 Copay	
General Anesthesia (Each 15 Increment)	9223/9243	\$95 Copay	
Class III Services: Major Restorative Care			
Dentures (Full Upper/Lower)	5110/5120	\$275 Copay	
Crown (Porcelain Fused to High Noble Metal)**	2750	\$250 Copay	
Bleaching (Home Application, Per Arch)	9975	\$165 Copay	
Class IV Services: Orthodontia			
Benefit — Child (Up to 19th Birthday)	8670	\$2,184 Copay	
Benefit — Adult	8670	\$2,904 Copay	
Pre-Treatment Visit	8660	\$68 Copay	
Records/Treatment Planning	8999	\$195 Copay	
Retention	8680	\$345 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 Access network.



Plan References

*Excluding final restoration.

**Copayments do not include the additional cost of Precious (High Noble) and Semi-Precious (Noble) Metal. The additional cost of Precious Metal shall not exceed \$130 per unit and \$80 per unit for Semi-Precious Metal.



Important Notes

- The summary has been provided as a convenient reference. For a full listing of covered services, exclusions and stipulations please see the plan's Schedule of Benefits or contact Cigna's customer service.
- Age limitations, waiting periods and service limits may apply.



Dental Insurance

Cigna Total DPPO Plan

The Village offers dental insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Cigna's customer service.

Dental Insurance – Cigna Total DPPO Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$19.62
Employee + One	\$49.25
Employee + Family	\$73.88

In-Network Benefits

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

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

Out-of-Network Benefits

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

Plan Year Deductible

The Total DPPO plan requires a \$50 individual or a \$150 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services. Once any three (3) covered members in a family each satisfy the \$50 deductible then deductible will be considered met for all covered members in that family.

Plan Year Benefit Maximum

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

Mobile App

Mobile app provides on-the-go access to the dental benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Locate a Provider
- Download Member ID Cards
- View Claims

Cigna Healthcare

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



Cigna Total DPP0 Plan At-A-Glance

Network		Total Network	
Plan Year Deductible (PYD)* October 1 to September 30		In-Network and Out-of-Network Combined	
Per Member		\$50	
Per Family		\$150	
Waived for Class I Services?		Yes	
Plan Year Benefit Maximum		In-Network	Out-of-Network*
Per Member <i>(Includes Class I Services)</i>		\$2,000	
Class I Services: Diagnostic & Preventive Care			
Routine Oral Exam <i>(2 Per Plan Year)</i>		Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived <i>(Subject to Balance Billing)</i>
Routine Cleanings <i>(2 Per Plan Year)</i>			
Bitewing X-rays <i>(2 Per Plan Year)</i>			
Complete X-rays <i>(1 Set Every 3 Plan Years)</i>			
Class II Services: Basic Restorative Care			
Fillings <i>(Amalgam or Composite)</i>		Plan Pays: 80% After PYD	Plan Pays: 80% After PYD <i>(Subject to Balance Billing)</i>
Simple Extractions			
Endodontics <i>(Root Canal Therapy)</i>			
Periodontal Services			
Oral Surgery			
Class III Services: Major Restorative Care**			
Crowns		Plan Pays: 50% After PYD	Plan Pays: 50% After PYD <i>(Subject to Balance Billing)</i>
Bridges			
Dentures			
Class IV Services: Orthodontia***			
Lifetime Maximum		\$1,000	
Benefit <i>(Children up to Age 19)</i>		Plan Pays: 50% Deductible Waived	Plan Pays: 50% Deductible Waived <i>(Subject to Balance Billing)</i>



Locate a Provider

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



Plan References

***Once any three (3) covered members in a family each satisfy the \$50 deductible then deductible will be considered met for all covered members in that family.**

****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.

*****Late Entrant Limitations will apply.**



Important Notes

- This dental plan runs on a plan year October 1 through September 30.
- Two (2) routine cleanings per plan year covered under the preventive benefit.
- Teeth missing prior to coverage under the plan are subject to limitations.
- For any dental work expected to cost \$200 or more, the plan will provide a "Pre-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.
- Age limitations, waiting periods and service limits may apply.



Vision Insurance

Cigna C1-Standard PPO Comprehensive Vision Plan (Serviced by EyeMed)

The Village offers vision insurance through Cigna Healthcare serviced by EyeMed 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 Cigna's customer service.

Vision Insurance

Cigna C1-Standard PPO Comprehensive Vision Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$4.27
Employee + Spouse	\$8.53
Employee + Child(ren)	\$8.61
Employee + Family	\$13.57

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employee and covered dependent(s) may select any network provider who participates in the Cigna Vision serviced by EyeMed 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

Employee and covered dependent(s) may choose to receive services from vision providers who do not participate in the Cigna Vision serviced by EyeMed network. When going out of network, the provider will require payment at the time of appointment. Cigna will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

If employee visits an out-of-network provider, they can submit a completed Cigna Vision Claim Form and itemized receipt to:

Cigna Vision, Claims Department c/o FAA
PO Box 8504
Mason, OH 45040-7111

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

Mobile App

Mobile app provides on-the-go access to the vision benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Locate a Provider
- Download Member ID Cards
- View Claims

Cigna Healthcare

Customer Service: (888) 353-2653 | www.mycigna.com



Cigna C1-Standard PPO Comprehensive Vision Plan At-A-Glance

Network		Cigna Vision Serviced by EyeMed	
Services		In-Network	Out-of-Network
Eye Exam		\$10 Copay	Up to \$45 Reimbursement
Materials		\$15 Copay	Reimbursement is Based on Type of Service
Frequency of Services			
Examination		One Per Calendar Year	
Lenses		One Per Calendar Year	
Frames		One Per Two Calendar Years	
Contact Lenses		One Per Calendar Year	
Lenses			
Single		\$15 Materials Copay	Up to \$32 Reimbursement
Bifocal			Up to \$55 Reimbursement
Trifocal			Up to \$65 Reimbursement
Frames			
Eye Glass Frames		Up to \$100 Allowance After \$15 Materials Copay; Then 20% Discount On Balance Over \$100	Up to \$55 Reimbursement
Contact Lenses*			
Elective		Up to \$110 Allowance	Up to \$98 Reimbursement
Non-Elective; Medically Necessary (Prior Authorization Required)		No Charge	Up to \$210 Reimbursement



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 the Cigna Vision serviced through EyeMed network.



Plan References

* Member may choose contact lenses benefit or lenses benefit.



Important Notes

- Benefits cannot be used in conjunction with other discounts, promotions or prior orders. A member who elects to use other discounts and/or promotions in lieu of his/her vision benefits may file a claim to receive reimbursement according to the out-of-network reimbursement amounts.
- Members may receive up to a 20% savings on additional frames and lenses purchased with a valid prescription.



Flexible Spending Accounts

The Village offers Flexible Spending Accounts (FSA) administered through HSABank. The FSA plan year is from October 1 to September 30.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employees to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year. There are three (3) types of FSAs:

- **Health Care FSA:** Available to eligible employee **not** enrolled in the Cigna HDHP Open Access Plus Plan. Covers medical, dental, and vision expenses that are not paid by insurance.
- **Limited Purpose FSA:** Available to eligible employee enrolled in the Cigna HDHP Open Access Plus Plan. A Limited Purpose Health Care FSA may be used for qualified dental and vision expenses.
- **Dependent Care FSA:** Covers day care expenses for qualified dependents necessary for employee and legal spouse, if married, to work.

Health Care FSA	Dependent Care FSA
This account allows participant to set aside up to an annual maximum of \$3,300. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). Examples of common expenses that qualify for reimbursement are listed below.	This account allows participant to set aside up to an annual maximum of \$5,000 if single or married and file a joint tax return (\$2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults. Please note, if family income is over \$20,000, this reimbursement option will likely save participants more money than dependent day care tax credit taken on a tax return. To qualify, dependents must be: • A child under the age of 13, or • A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household. <i>Nondiscrimination rules may affect the benefits available to highly-compensated or key employees.</i>
<i>Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.</i>	<i>Please Note: Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from participant's paycheck for the Dependent Care FSA.</i>

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

- | | | |
|---|---|-------------------------------|
| ✓ Prescription/Over-the-Counter Medications | ✓ Physician Fees and Office Visits | ✓ LASIK Surgery* |
| ✓ Menstrual Products | ✓ Drug Addiction/Alcoholism Treatment | ✓ Mental Health Care |
| ✓ Ambulance Service | ✓ Experimental Medical Treatment | ✓ Nursing Services |
| ✓ Chiropractic Care | ✓ Corrective Eyeglasses and Contact Lenses* | ✓ Optometrist Fees* |
| ✓ Dental and Orthodontic Fees* | ✓ Hearing Aids and Exams | ✓ Sunscreen SPF 15 or Greater |
| ✓ Diagnostic Tests/Health Screenings* | ✓ Injections and Vaccinations | ✓ 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 Accounts *(Continued)*

FSA Guidelines

- Employee may carry over up to \$660 of unused Health Care or Limited Purpose FSA funds into the next plan year after a plan year ends and all claims have been filed (only if the employee re-enrolls the next year). Dependent Care funds cannot be carried over.
- The Health Care, Limited Purpose or Dependent Care FSAs have a 60 day run out period at the end of the plan year to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year.
- Employee can enroll in an FSA only during the Open Enrollment Period, New Hire Orientation or Qualifying Events.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services they have not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible in the employee FSA as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

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

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. HSABank may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the Village. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!



An employee earning \$50,000 elects to place \$1,000 into a Health Care FSA. The payroll deduction is \$41.67 based on a 24 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of \$197.

	With a Health Care FSA	Without a Health Care FSA
Salary	\$50,000	\$50,000
FSA Contribution	- \$1,000	- \$0
Taxable Pay	\$49,000	\$50,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- \$9,628	- \$9,825
After Tax Expenses	- \$0	- \$1,000
Spendable Income	\$39,372	\$37,175
Tax Savings	\$197	

Please Note: Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the \$660 carry over that may be allowed for the Health Care or Limited Purpose FSA. This rule is known as "use-it or lose-it."

Mobile App

Mobile app provides on-the-go access to the FSA benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- File a Claim
- View Account Activity
- View Item for Eligibility
- Upload Receipts

Claims Mailing Address

HSABank | PO Box 939, Sheboygan, WI 53082

HSABank | Customer Service: (800) 357-6246 | www.hsabank.com



Employee Assistance Program

The Village 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 Aetna Resources for Living. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program (EAP) offers covered employees and 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 or family member's well-being. Coverage includes three (3) visits with a specialist, per person, per issue, per year, online material/tools and webinars. EAP offers counseling services on issues such as:

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

Are Services Confidential?

Yes. Receipt of EAP Services is completely confidential. If, however, participation in the EAP is a 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.

Aetna Resources for Living

Customer Service: (888) 238-6232 | www.resourcesforliving.com

Username: MYRPBEAP | Password: EAP

Basic Life and AD&D Insurance

Basic Term Life Insurance

The Village provides Basic Term Life insurance for all eligible full-time employees working 40 hours per week at no cost, through New York Life Group Benefit Solutions. Eligible employees will receive a benefit amount based upon employment classification.

- › Full-time employees receive a benefit amount equal to one (1) times their annual salary with a maximum of \$150,000.
- › Executive employees receive a benefit amount equal to one (1) times annual salary with a maximum of \$300,000.
- › Executive Officials and Mayor receive a benefit amount equal to \$30,000.

Retirees are eligible to continue their Life Insurance benefit, not to exceed \$150,000, at the group premium rate.

Basic Accidental Death & Dismemberment Insurance

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

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- › Reduces to 65% of the benefit amount at age 65
- › Reduces to 45% of the benefit amount at age 70
- › Reduces to 30% of the benefit amount at age 75
- › Reduces to 20% of the benefit amount at age 80

Life Insurance Imputed Income

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

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

New York Life Group Benefit Solutions

Customer Service (800) 362-4462 | www.mynylgbs.com



Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible full-time employee working 40 hours per week may elect to purchase additional life insurance on a voluntary basis through New York Life Group Benefit Solutions. This coverage may be purchased in addition to the Basic Term Life and AD&D coverage. Voluntary Life insurance offers coverage for employee, spouse or dependent child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of \$100,000.

- Units can be purchased in increments of \$10,000 to the maximum of \$500,000, not to exceed five (5) times annual salary.
- Benefit amounts are subject to the following age reduction schedule:
 - Reduces to 65% of the benefit amount at age 65
 - Reduces to 45% of the benefit amount at age 70
 - Reduces to 30% of the benefit amount at age 75
 - Reduces to 20% of the benefit amount at age 80

2025 Open Enrollment: Employees may enroll or increase coverage up to but not exceeding the Guaranteed Issue amount of \$100,000, without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). All others will need to complete an EOI. Please contact Payroll/Benefits or Human Resources for additional information.

Voluntary Spouse Life Insurance

New Hires may purchase Voluntary Spouse Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of \$20,000.

- Employee must participate in the Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of \$10,000 to a maximum of \$250,000.
- As long as employee has approved coverage, spouse coverage may equal or exceed employee coverage amount.
- Spouse coverage will terminate at age 70.

2025 Open Enrollment: Employees may enroll or increase coverage for spouses up to but not exceeding the Guaranteed Issue amount of \$20,000, without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). All others will need to complete an EOI. Please contact Payroll/Benefits or Human Resources for additional information.

Voluntary Employee Life Rate Table

Monthly Rates

Age Bracket (Based on Employee Age)	Employee/Spouse (Rate Per \$1,000 of Benefit)
Under Age 20	\$0.068
20-34	\$0.107
35-39	\$0.130
40-44	\$0.187
45-49	\$0.282
50-54	\$0.448
55-59	\$0.720
60-64	\$1.104
65-69	\$1.870
70-74	\$3.466
75-99	\$7.000

Voluntary Dependent Child(ren) Life Insurance

- Employee must participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- Coverage may be purchased for dependent child(ren) under six (6) months for a \$1,000 benefit.
- Coverage may be purchased for dependent child(ren) age six (6) months up to the date in which the dependent child reaches age 19 (25 years of age if unmarried and a full-time student) in increments of \$2,500 up to \$10,000. This can be purchased for a flat rate per month for all children on the plan.

New York Life Group Benefit Solutions

Customer Service (800) 362-4462 | www.mynylgbs.com



Short Term Disability Insurance

The Village provides Short Term Disability (STD) insurance at no cost to all eligible full-time employees working 40 hours per week and have at least one (1) year of full-time service through New York Life Group Benefit Solutions. The STD benefit pays employee a percentage of weekly earnings if employee becomes disabled due to an illness or non-work related injury.

Short Term Disability (STD) Benefits

- STD provides a benefit of 75% of employee's weekly earnings.
- Employee must be disabled for four (4) consecutive weeks prior to becoming eligible for benefits (known as the elimination period).
- The maximum benefit period is 26 weeks inclusive of the four (4) week elimination period.
- Employee deemed unable to return to work after the STD 26 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefits may be reduced by other income.
- Disability benefits may be taxable.

New York Life Group Benefit Solutions

Customer Service (800) 362-4462 | www.mynylgbs.com

Long Term Disability Insurance

The Village provides Long Term Disability (LTD) insurance at no cost to all eligible full-time employees working 40 hours per week and have at least one (1) year of full-time service through New York Life Group Benefit Solutions. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of \$7,500 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefit payments will begin on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.
- Disability benefits may be taxable.

New York Life Group Benefit Solutions

Customer Service (800) 362-4462 | www.mynylgbs.com

Employee Assistance and Wellness Support

Feeling overwhelmed by the demands of balancing work and family life? New York Life Group Benefit Solutions Employee Assistance and Wellness Support can help find solutions and restore peace. Available to employees who are currently enrolled in New York Life Group Benefit Solutions' group life, accident or disability coverage, programs include:

- Employee Assistance Program
- Well-being Coaching
- GuidanceResources
- FamilySource

New York Life Group Benefit Solutions

Customer Service: (800) 344-9752 | www.guidanceresources.com

Web ID: NYLGBS

Financial, Legal & Estate Support

New York Life Group Benefit Solutions Guidance Resources makes it easy for employees to take charge of those difficult life and health legal decisions. Available to employees who are currently enrolled in New York Life Group Benefit Solutions' group life, accident, or disability coverage, Guidance Resources allows employee to easily complete essential life and health legal documents online at no cost to employee. Guidance Resources is secure, easy to use, and available to employee and covered spouse seven (7) days a week, 365 days a year. Available programs include, but are not limited to:

- ✓ FinancialConnect
- ✓ LegalConnect
- ✓ EstateGuidance

To register, please visit www.guidanceresources.com

New York Life Group Benefit Solutions

Customer Service: (800) 344-9752 | www.guidanceresources.com

Web ID: NYLGBS



Supplemental Insurance

Teladoc

Teladoc provides \$0 Copay 24/7 access to a medical doctor in your state via phone or video consultation that can diagnose and prescribe most non-DEA controlled medications. The company provides medical assistance for many non-emergent, common conditions in 15 minutes or less. This benefit is provided to full-time employees, enrolled or not enrolled in the group health plan, free for one (1) year. There is also a family upgrade that is available at no additional cost (up to five (5) dependents). These dependents must be added by the primary member after the primary member confirms their own eligibility with Teladoc.

This benefit is provided by Village of Royal Palm beach, not by your health insurance carrier. To set up your free Teladoc account, call (800) 835-2362, download the app at www.Teladoc.com/Mobile, or visit member.teladoc.com/registrations on the web. Teladoc doctors do not replace a primary care physician, but maybe a convenient alternative for common conditions that sometimes result in urgent care and ER visits due to the time of day, location, or convenience. For further information, please contact Payroll/Benefits or Human Resources or contact the Teladoc Agent directly.

Teladoc | Customer Service: (800) 835-2362 | www.teladoc.com
 Agent: Abby Woll | Phone: (860) 217-0851 ext 104
 Email: awoll@cadplus.com

Aflac

Aflac offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums are paid by payroll deduction on an after-tax basis for most products. Aflac pays money directly to employee, regardless of what other insurance plans an employee may have. To learn more about these Aflac plans and/or to schedule a personal appointment, contact the Village's Aflac agent. Details regarding available Aflac plans and services are also accessible online at <https://www.aflacenrollment.com/VillageofRoyalPalmBeach/qt4873008348>.

Available Aflac plans include coverages for:

- ✓ Life Protector (Life Insurance) & Juvenile Life
- ✓ Accident Indemnity Advantage
- ✓ Aflac Cancer Care
- ✓ Critical Care (Specified Health Event)
- ✓ Personal Disability Income Protector
(Short Term Disability – Guaranteed Issue)
- ✓ Hospital Advantage (Guaranteed Issue Options)

Aflac | Customer Service: (800) 992-3522
<https://www.aflacenrollment.com/VillageofRoyalPalmBeach/qt4873008348>
 Agent: Katty Cohen | Phone: (561) 414-0032
 Email: katty_cohen@us.aflac.com

Washington National

Washington National offers a variety of voluntary supplemental insurance plans through Washington National Insurance Company to help employee cover unexpected costs that can come with accidents, hospitalization, critical illness or loss of life. Additionally, Washington National offers a Return of Premium feature that returns all premiums back to employees minus any claims when an employee stays healthy and does not need to use the coverage. Available Washington National plans include coverage for:

- ✓ Cancer Coverage
- ✓ Critical Illness Coverage (*Heart Attack | Stroke & More*)
- ✓ Accidental Injury Coverage
- ✓ Hospitalization Coverage
- ✓ Guarantee Issue Life Insurance

Washington National

Customer Service: (800) 525-7662 | www.washingtonnational.com
 Agent: Tucker Doucette | Phone: (727) 251-0603



Supplemental Insurance *(Continued)*

LegalShield

The Village offers employee the opportunity to participate in a voluntary pre-paid legal program offered through LegalShield. By enrolling in the legal plan, participant and family member(s) will have direct access to a nationwide network of law firms for a variety of situations. Dependents are covered up to age 26, if living at home or a student. The plan provides assistance, but is not limited to the following benefits:

- | | |
|---------------------------|-------------------------|
| ✓ Uncontested Divorce* | ✓ Traffic Tickets |
| ✓ Child Custody & Support | ✓ Wills & Living Trusts |
| ✓ Civil Litigation | ✓ Real Estate |
| ✓ Bankruptcy | ✓ Credit Report Issues |
| ✓ Name Changes | ✓ Contract Review |
| ✓ Criminal Defense | ✓ Adoption* |

** Please Note: These services require a 90 Day Waiting Period.*

IDShield

The Village also offers employee the opportunity to participate in an identity theft plan called IDShield through LegalShield which protects employee, spouse and child(ren). IDShield can provide:

- Identity Consultation and Advice
- Credit Report with Analysis
- Privacy & Security Monitoring
- Identity & Credit Monitoring
- Restoration Benefits
- Financial Protection - \$3 Million Identity Fraud Protection for unauthorized electronic fund transfers and identity theft related expenses.

There are many additional features offered along with the plan benefits such as licensed investigators being available 24 hours a day, seven (7) days a week, lost wallet assistance and fraud alerts.

Plan benefits include unlimited phone consultations. For additional information, please contact the Village's dedicated Agent Barry Olfern as listed below, or visit the following website: <https://shieldbenefits.com/royalpalmbeach/overview>.

LegalShield | Customer Service: (800) 654-7757
Agent: Barry Olfern | Phone: (954) 655-2446
Email: barryolfern@gmail.com



Florida Retirement System

Florida Retirement System (FRS)

The Florida Retirement System is a state-administered retirement program for employees who are employed in regularly established positions. Employees may choose to participate in the FRS Pension Plan or the FRS Investment Plan.

FRS Pension Plan

The FRS Pension Plan is a traditional, defined-benefit retirement plan. For employees hired prior to July 1, 2011, vesting occurs after six (6) years of service. For employees hired on or after July 1, 2011, vesting occurs after eight (8) years of service.

FRS Investment Plan

The FRS Investment Plan is a defined contribution plan where employees allocate employer and employee contributions to available investments. Vesting occurs after one (1) year of service. The benefit for this plan is based on how much money is contributed to an employee’s account and how well that money grows over time when invested. Employees choose from several available payout options when the benefit is taken.

FRS

Investment Plan: (866) 446-9377 | www.myfrs.com
Pension Plan: (844) 377-1888 | www.frs.myflorida.com

Retirement Plans

The Village offers 457b Deferred Compensation programs through the MissionSquare Retirement, Prudential and VALIC as follows:

Traditional 457b Plan

Employees may set aside pre-tax dollars toward retirement savings through automatic payroll deductions, which reduces taxes that are paid out today. The money contributed to this type of account, including earnings, accumulates on a tax-deferred basis. Withdrawals of contributions and earnings are subject to Federal and State (if applicable) income taxes in effect at the time of withdrawal.

2025 Contribution Limits

457b	
Annual Deferral Limit for 457b Plans	\$23,000
“Pre-Retirement” Catch-Up Limit	\$23,000 (\$46,000 Total)
“Age 50” Catch-Up Limit	\$7,500 (\$30,500 Total)

There is no employer matching for this program, and is subject to minimum and maximum participation amounts. Employees can choose to contribute to the 457b Deferred Compensation program by contacting the representatives listed below.

MissionSquare Retirement (ICMA)

Customer Service: (800) 669-7400 | www.missionsq.org
Retirement Plan Specialist: Steven Feigelis
Cell: (202) 759-7058 | Email: sfeigelis@missionsq.org

Empower (Prudential)

Customer Service: (800) 701-8255 | www.empower.com
Agent: Richard R. Fulton | Cell: (561) 670-5501

Corebridge Financial Retirement Services (VALIC)

Agent: Tony Tringali | Office: (561) 684-3775 | Phone: (772) 521-2007



Notes

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

Handwriting practice lines (dotted lines) for notes.

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3500 Kyoto Gardens Drive, Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970 | www.gehringgroup.com

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