The Village of ROYAL PALM BEACH FLORIDA

Incorporated 1959

2021|2022

EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

	Human Resources	Human Resources	Phone: (561) 790-5120
	Employee Self Service	Payroll Department	Phone: (561) 790-5117
	Medical Insurance	Cigna	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
HSA	**Health Savings Account**	HSABank	Customer Service: (800) 357-6246 www.hsabank.com | Lost HSA Cards: (866) 679-7649
HRA	**Health Reimbursement Account**	HSABank	Customer Service: (800) 357-6246 www.hsabank.com
	Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	Cigna	Customer Service: (877) 478-7557 www.mycigna.com
FSA	**Flexible Spending Accounts**	HSABank	Customer Service: (800) 357-6246 www.hsabank.com
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions (Formerly Cigna Life)	Customer Service (800) 362-4462 www.mynylgbs.com
	Voluntary Life Insurance	New York Life Group Benefit Solutions (Formerly Cigna Life)	Customer Service (800) 362-4462 www.mynylgbs.com
	Short Term Disability Insurance	New York Life Group Benefit Solutions (Formerly Cigna Life)	Customer Service (800) 362-4462 www.mynylgbs.com
	Long Term Disability Insurance	New York Life Group Benefit Solutions (Formerly Cigna Life)	Customer Service (800) 362-4462 www.mynylgbs.com
	Long Term Care	Unum Provident	Customer Service: (866) 679-3054 www.unumifo.com/VORPB
	Employee Assistance Program	Aetna Resources for Living	Customer Service: (888) 238-6232 www.resourcesforliving.com Username: MYRPBEAP Password: EAP
	Supplemental Insurance	Aflac	Agent: Katty Cohen | Phone: (561) 414-0032 Email: katty_cohen@us.aflac.com Customer Service: (800) 992-3522 | www.aflac.com
		Teladoc	Agent: Christopher Schoder | Phone: (954) 823-0266 Email: cschoder@cadrplus.com | www.teladoc.com
		LegalShield	Agent: Barry Olfern | Phone: (954) 655-2446 Email: barryolfern@legalshieldassociate.com Customer Service: (800) 654-7757 www.legalshield.com
		PMA USA (Washington National Formerly Conseco)	Agent: Thomas Hunt | Phone: (724)-813-4035 www.washingtonnational.com
	Retirement Plans	FRS	Pension Customer Service: (844) 377-1888 | www.frs.myflorida.com Investment/Financial Guidance: (866) 446-9377 | www.myfrs.com
		MissionSquare Retirement (Formerly ICMA)	Agent: Steven Feigelis | Office: (561) 963-1681 | Cell: (202) 701-5969
		Prudential	Agent: Richard R. Fulton | Cell: (561) 670-5501
		VALIC	Agent: Amber Girtman | Office: (561) 684-3775 | Cell: (561) 906-0846

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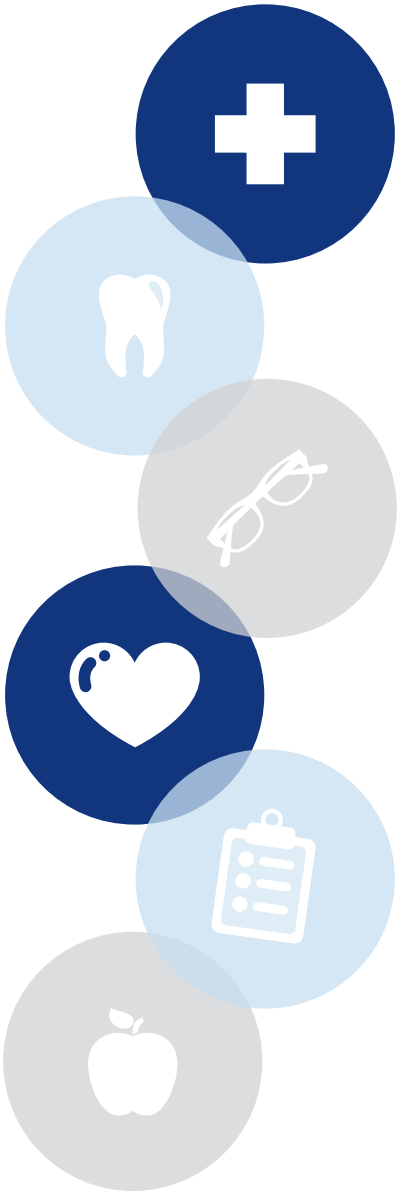

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This booklet is merely a summary of benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The Village of Royal Palm Beach reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

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 Human Resources for further information.

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 30 hours per week. 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 will continue through the end of the 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 and/or dependent child(ren) of the participant or spouse. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to the age of 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/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 may continue to be covered on the medical plan to the end of the plan 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 medical plan; and
- The dependent has been continuously insured

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

Group Insurance Eligibility *(Continued)*

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

- **Medical Insurance:** 80% of the premium for the Cigna Medical Plan
- **Dental Insurance:** 80% of the premium for the Cigna 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 Human Resources.

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

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided as a supplement to this booklet which is being distributed to new hires and existing employees during 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:	Human Resources
Address:	1050 Royal Palm Beach Blvd. Royal Palm Beach, FL 33411
Phone:	(561) 790-5120
At Website URL:	www.royalpalmbeach.com

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 Human Resources.

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

Other Available Plan Resources

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

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 Healthy Rewards to learn more about these programs or contact (800) 870-3470.

- ✓ Vision Care
- ✓ Lasik Vision Correction Services
- ✓ Fitness Club Discounts
- ✓ Nutrition Discounts
- ✓ Hearing Care

The myCigna Mobile App

The myCigna mobile app is an easy way to organize and access important health information. Anytime. Anywhere. Download it today from the App Store℠ or Google Play™. With the myCigna mobile app, member can:

- ✓ Find a doctor, dentist or health care facility
- ✓ Access maps for instant driving directions
- ✓ View ID cards for the entire family
- ✓ Review deductibles, account balances and claims
- ✓ Compare prescription drug costs
- ✓ Speed-dial Cigna Home Delivery Pharmacy™
- ✓ Store and organize all important contact info for doctors, hospitals, and pharmacies
- ✓ Add health care professionals to contact list right from a claim or directory search

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.

Cigna HDHP Open Access Plus Plan At-A-Glance

Network	Open Access Plus	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network***
Single	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance		
Member Responsibility	10%	30%
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, and Copays (Including Rx)	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	10% After PYD	30% After PYD
Specialist Office Visit *(No Referral Required)*	10% After PYD	30% After PYD
Telehealth Services	10% After PYD	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	10% After PYD	30% After PYD
X-rays	10% After PYD	30% After PYD
Advanced Imaging *(MRI, PET, CT)*	10% After PYD	30% After PYD***
Outpatient Surgery in Surgical Center	10% After PYD	30% After PYD
Physician Services at Surgical Center	10% After PYD	30% After PYD
Urgent Care *(Per Visit)*	10% After PYD	10% After PYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After PYD	30% After PYD
Outpatient Hospital *(Per Admission)*	10% After PYD	30% After PYD
Physician Services at Hospital	10% After PYD	30% After PYD
Emergency Room *(Per Visit)*	10% After PYD	10% After PYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After PYD	30% After PYD
Outpatient Services *(Per Visit)*	10% After PYD	30% After PYD
Outpatient Office Visit	10% After PYD	30% After PYD
Prescription Drugs *(Rx)*		
Generic	$10 Copay After PYD	30% 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.*

***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

The Village'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 medical expenses not covered by the plan.

2021-2022 Funding

The Village will fund 2/3 of the annual Out-of-Pocket Maximum for the plan year between October – September: $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).

- **2021 IRS Contribution Limitations:**
  $3,600 (individual coverage) $7,200 (family coverage)
- **2022 IRS Contribution Limitations**:
  $3,650 (individual coverage) $7,300 (family coverage)

Please Note: *Individuals ages 55 and older can also make additional "catch-up" contributions up to $1,000 annually.*

Guidelines regarding the HSA are established by the IRS.

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 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 amounts.
- 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 amounts. 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.

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

Health Reimbursement Account

The Village's provides a Health Reimbursement Account (HRA) for employees 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 HRAs are 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.

2021-2022 Funding

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

If employee has the HRA and also elects an FSA, FSA monies will be used first, as it is employee-funded and does not rollover from year to year.

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 is 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.

Paper Claim

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, which is indicated on the paper claims form. The form can be found at www.hsabank.com.

Claims Mailing Address
HSABank | PO Box 939, Sheboygan, WI 53082

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

Dental Insurance

Cigna Dental Care DHMO (FAOV9) Plan

The Village 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 carrier's summary plan document or contact Cigna's customer service.

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.

IMPORTANT NOTES

- *Each covered family member may receive two (2) routine cleanings per plan year covered under the preventive benefit. 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 age13 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 | 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)	**In-Network Only**	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Plan Year Benefit Maximum	**In-Network Only**	
Per Member	Does Not Apply	
Class I Services: Diagnostic & Preventive Care	**Code**	**In-Network**
Office Visit	N/A	$5 Copay
Oral Evaluation	0120	$0 Copay
Routine Cleanings *(2 Per Plan Year)*	1110/1120	$0 Copay
Bitewing X-rays *(2 Per Plan Year)*	0272	$0 Copay
Complete X-rays *(1 Set Every 3 Years)*	0210	$0 Copay
Fluoride Treatments *(2 Per Plan Year)*	1206	$0 Copay
Sealants *(Per Tooth)*	1351	$0 Copay
Class II Services: Basic Restorative Care		
Fillings *(Amalgam; 1 Surface: Primary or Permanent)*	2140	$0 Copay
Fillings *(Composite; 1 Surface: Anterior)*	2330	$0 Copay
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.*

Dental Insurance

Cigna Total DPPO Plan

The Village 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 carrier's summary plan document or contact Cigna's customer service.

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 Cigna DPPO 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 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.

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

Cigna Total DPPO Plan At-A-Glance

Network	Total Cigna DPPO	
Plan Year Deductible (PYD)	**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 *(Includes Class I Services)*	$2,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Plan Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Plan Year)*		
Bitewing X-rays *(2 Per Plan Year)*		
Complete X-rays *(1 Set Every 3 Plan Years)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam or Composite)*	Plan Pays: 80% After PYD	Plan Pays: 80% After PYD *(Subject to Balance Billing)*
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Periodontal Services		
Oral Surgery		
Class III Services: Major Restorative Care**		
Crowns	Plan Pays: 50% After PYD	Plan Pays: 50% After PYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Class IV Services: Orthodontia**		
Lifetime Maximum	$1,000	
Benefit *(Children up to Age 19)*	Plan Pays: 50%	Plan Pays: 50% *(Subject to Balance Billing)*

Locate a Provider

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

Plan References

***Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Out-of-Network Benefits section on the previous page.*

***Late Entrant Limitations will apply.*

Important Notes

- *Each covered family member may receive two (2) routine cleanings per plan year covered under the preventive benefit.*
- *Teeth missing prior to coverage under the plan are not covered.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" 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 CI-Standard PPO Comprehensive Vision Plan

The Village offers vision insurance through Cigna to benefit-eligible employees. 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.

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 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 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
PO Box 385018
Birmingham, AL 35238-5018

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.

Cigna | Customer Service: (877) 478-7557 | www.cigna.com

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

Network	Cigna Vision	
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	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
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 20% Discount After the Allowance	Up to $55 Reimbursement
Contact Lenses*		
Elective *(Includes Fitting, Evaluation & Follow-up)*	Up to $110 Allowance	Up to $98 Reimbursement
Non-Elective; Medically Necessary *(Prior Authorization Required)*	Covered 100%	Up to $210 Reimbursement

Locate a Provider

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

Plan References

** Contact lenses are in lieu of spectacle lenses.*

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 age 65 or older and 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 under the age of 65 and 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

This account allows participant to set aside up to an annual maximum of $2,750. 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.

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 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.

Nondiscrimination rules may affect the benefits available to highly-compensated or key employees.

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.

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

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees*
- ✓ Diagnostic Tests/Health Screenings*
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses*
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery*
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees*
- ✓ Sunscreen SPF 15 or Greater
- ✓ 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 $550 of unused Health Care or Dependent Care FSA funds into the next plan year after a plan year ends and all claims have been filed. Dependent Care funds cannot be carried over.
- The Health Care, Limited Purpose or Dependent Care FSAs have a run out period at the end of the plan year (60 Days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year.
- When a plan year ends and all claims have been filed, all unused funds with the exception of the $550 rollover for the Health Care or Limited Purpose FSA will be forfeited and not returned.
- Employee can enroll in an FSA only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility period.
- 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 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 $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, 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	$30,000	$30,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$29,000	$30,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $5,698	- $5,895
After Tax Expenses	- $0	- $1,000
Spendable Income	$23,302	$23,105
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 $550 carry over that may be allowed for the Health Care or Limited Purpose FSA.* ***This rule is known as "use-it or lose-it."***

Claims Mailing Address
HSABank | PO Box 939, Sheboygan, WI 53082

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

Basic Life and AD&D Insurance

Basic Term Life Insurance

The Village provides Basic Term Life insurance for all eligible employees 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 $115,000.
- Executive employees receive a benefit amount equal to one (1) times annual salary with a maximum of $250,000.
- Executive Officials and Mayor receive a benefit amount equal to $30,000.

Retirees are eligible to continue their Life Insurance benefit 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 Human Resources.

New York Life Group Benefit Solutions (Formerly Cigna Life)
Customer Service (800) 362-4462 | www.mynylgbs.com

Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible employee 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

Voluntary Spouse Life Insurance

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 $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.
- Spouse coverage will terminate at age 70.

Voluntary Dependent Child(ren) Life Insurance

- Employee must participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- Children six (6) months to 19 years (up to 25 years of age if unmarried and a full-time student): coverage can be purchased 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.
- Children 14 days to six (6) months will be covered for a $1,000 benefit.

New York Life Group Benefit Solutions (Formerly Cigna Life)
Customer Service (800) 362-4462 | www.mynylgbs.com

Short Term Disability

The Village provides Short Term Disability (STD) insurance at no cost to all eligible employees through New York Life Group Benefit Solutions. The STD benefit pays employee a percentage of the 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.
- 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 are taxable.

New York Life Group Benefit Solutions (Formerly Cigna Life)
Customer Service (800) 362-4462 | www.mynylgbs.com

Long Term Disability

The Village provides Long Term Disability (LTD) insurance at no cost to all eligible employees through New York Life Group Benefit Solutions. The LTD benefit pays 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.

New York Life Group Benefit Solutions (Formerly Cigna Life)
Customer Service (800) 362-4462 | www.mynylgbs.com

Cigna's My Secure Advantage

Cigna makes it easy for employees to take charge of those difficult life and health legal decisions. Available to individuals who are currently enrolled in Cigna's group life, accident, or disability coverage, My Secure Advantage allows employee to easily complete essential life and health legal documents online at no cost to employee. My Secure Advantage 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:

- ✓ Last Will and Testament
- ✓ Living Will
- ✓ Healthcare Power of Attorney
- ✓ Financial Power of Attorney
- ✓ Personal Estate Planning
- ✓ Identity Theft Information Kit
- ✓ Cigna's Life and Disability Planning Kit

To register, please visit cigna.mysecureadvantage.com.

Cigna | Customer Service: (888) 724-2262 | cigna.mysecureadvantage.com

Long Term Care Insurance

Unum

Long Term Care is the assistance received when someone needs help with two (2) 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 Village offers coverage in the form of a fixed dollar indemnity benefit if employee becomes disabled. Coverage is subject to policy limitations, benefit maximums and elimination periods.

Benefit Duration	3 Years	6 Years	Lifetime
Facility Benefit Amount Per $1,000 Increments	$1,000 to $9,000	$1,000 to $9,000	$1,000 to $9,000
Assisted Living Facility Percent	100%	100%	100%
Lifetime Maximum Per $1,000 Increments	$36,000	$72,000	N/A
Professional Home Care	100%	100%	100%
Total Home Care — Option	50%	50%	50%

Unum | Customer Service: (866) 679-3054 | www.unum.com
To enroll please visit http://unuminfo.com/VORPB

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) face-to-face, visits with a specialist, per person, per issue, per year, telephonic consultation, 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/manager. The referring supervisor will not receive specific information regarding the referred employee's case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Aetna Resources for Living
Customer Service: (888) 238-6232 | www.resourcesforliving.com
Username: MYRPBEAP | Password: EAP

Supplemental Insurance

Teladoc

Teladoc provides 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 year. Part-time employees may purchase this benefit for a monthly fee. 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 1-800-835-2362, download the app at HYPERLINK "http://www.Teladoc.com/Mobile" www.Teladoc.com/Mobile, or visit member.teladoc.com/registrations/get_started 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 Human Resources or contact the Teladoc Agent directly.

Agent: Christopher Schoder
Phone: (954) 873-0266 | Email: cschoder@cadrplus.com
Teladoc | Customer Service: (800) 835-2362 | www.teladoc.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 www.aflac.com. 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)

Agent: Katty Cohen
Phone: (561) 414-0032 | Email: katty_cohen@us.aflac.com
Aflac | Customer Service: (800) 992-3522 | www.aflac.com

Supplemental Insurance *(Continued)*

LegalSheild

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:

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

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

There are many additional features offered along with the plan benefits such 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.

Agent: Barry Olfern
Phone: (954) 655-2446 | Email: barryolfern@legalshieldassociate.com

LegalShield | Customer Service: (800) 654-7757

PMA USA

PMA USA offers a variety of voluntary supplemental insurance plans through Washington National Insurance Company to help employee cover unexpected costs that can come with accidents, critical illness or loss of life. Available Washington National plans include coverage for:

- ✓ Cancer Coverage
- ✓ Critical Illness Coverage
- ✓ Accident Coverage
- ✓ Guarantee Issue Life Insurance

Agent: Thomas Hunt | Phone: (724)-813-4035

Washington National
Customer Service: (800) 628-3428 | www.washingtonnational.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.

2021 Contribution Limits

457b	
Annual Deferral Limit for 457b Plans	$19,500
"Pre-Retirement" Catch-Up Limit	$19,500 ($39,000 Total)
"Age 50" Catch-Up Limit	$6,500 ($26,000 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 (Formerly ICMA)
Customer Service: (800) 669-7400 | www.icmarc.org
Retirement Plan Specialist: Steven Feigelis
Office: (561) 963-1681 | Cell: (202) 701-5969 | Email: sfeigelis@icmarc.org

Prudential | Agent: Richard R. Fulton | Cell: (561) 670-5501

VALIC | Agent: Amber Girtman | Office: (561) 684-3775 | Cell: (561) 906-0846

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.

GEHRING® GROUP

EMPLOYEE BENEFITS | RISK MANAGEMENT

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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