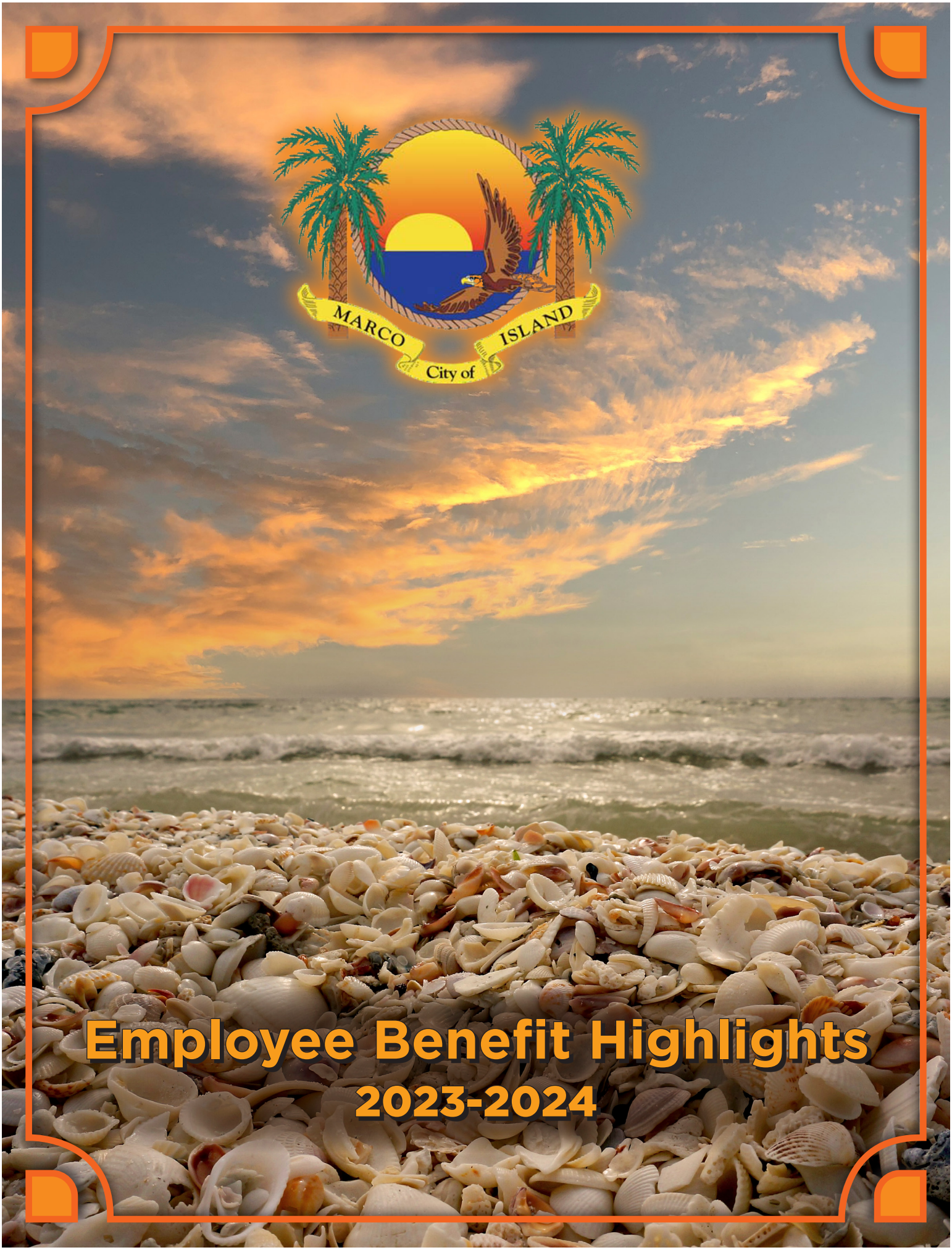

Employee Benefit Highlights

2023-2024

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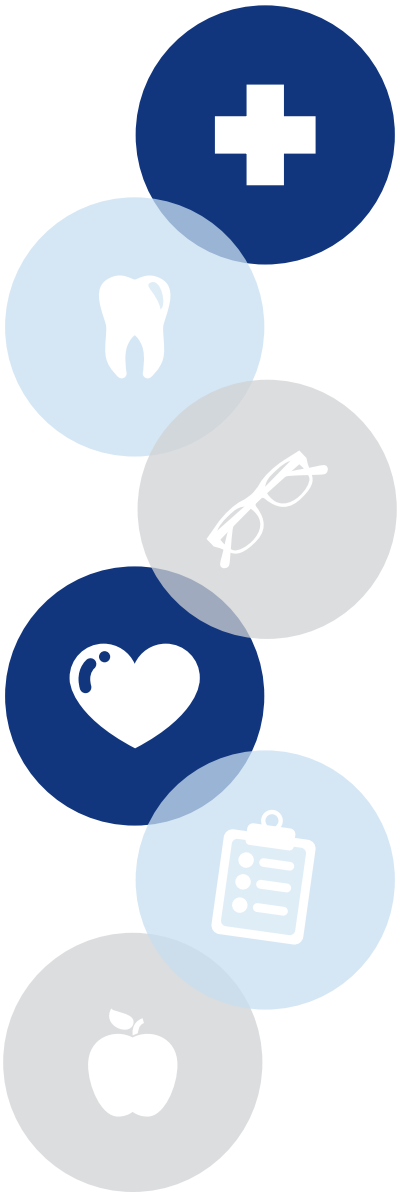


This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Marco Island reserves the right to amend, modify or terminate the plan at any time. This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

Contact Information

	Human Resources Administration	Leslie Sanford	Office: (239) 389-3970 Email: lsanford@cityofmarcoisland.com
	Claims, Billing & Benefit Assistance	Gehring Group	Phone: (800) 244-3696 Email: marcoisland@gehringgroup.com
	Medical Insurance	Cigna	Customer Service: (866) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
	Telehealth	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.mycigna.com
	Dental Insurance	The Standard	Customer Service: (800) 547-9515 www.standard.com/services
	Vision Insurance	The Standard	Customer Service: (800) 547-9515 www.standard.com/services
	Flexible Spending Accounts	Employee Benefits Corporation	Customer Service: (800) 346-2126 Claims Fax: (608) 831-4790 www.ebcflex.com
	Employee Assistance Program	HealthAdvocate	Customer Service: (888) 293-6948 www.healthadvocate.com/standard3
	Basic Life and AD&D Insurance	The Standard	Customer Service: (800) 628-8600 www.standard.com
	Voluntary Life Insurance	The Standard	Customer Service: (800) 628-8600 www.standard.com
	Voluntary Short Term Disability Insurance	The Standard	Customer Service: (800) 368-2859 www.standard.com
	Voluntary Long Term Disability Insurance	The Standard	Customer Service: (800) 368-1135 www.standard.com
	Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 www.aflac.com Local Agent: Anna Wiseman Phone: (239) 404-8894 Email: anna_wiseman@us.aflac.com
	Travel Assistance Program	Assist America	Customer Service: U.S., Canada, Puerto Rico, U.S. Virgin Islands, and Bermuda: (800) 872-1414 All other locations worldwide: +1(609) 986-1234 Text: (609) 334-0807 Email:medservices@assistamerica.com www.standard.com/travel Reference Number: 01-AA-STD-5201

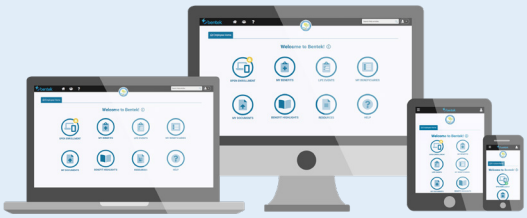
Introduction

The City of Marco Island provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the City's Personnel Policies and/or Procedures and group insurance 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.

Online Benefit Enrollment

The City provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Life 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 life events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/cityofmarcoisland**

  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 City's group insurance plan year is November 1 through October 31.

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are benefit-eligible employees working a minimum of 30 hours per week.

Coverage will be effective the first of the month following date of hire. For example, if employee is hired on May 11, then the effective date of coverage will be June 1.

Separation of Employment

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

Dependent Eligibility

A dependent is defined as the legal spouse/domestic partner and/or dependent child(ren) of the participant or spouse/domestic partner. 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 Statue)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner

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 Human Resources if further clarification is needed.

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 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 Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

Please see Taxable Dependents if covering eligible over-age dependents.

Taxable Dependents

Employee covering adult child(ren) under employee's medical insurance plan 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.

Group Insurance Eligibility *(Continued)*

Domestic Partner Coverage

Domestic partners may be eligible to participate in the City's group insurance plans if the partner is officially registered as a domestic partner with the City of Marco Island. The IRS guidelines state that employee may not receive a tax advantage on any portion of premiums paid related to domestic partner coverage. Employees insuring domestic partners and/or child dependent(s) of a domestic partner are required to pay imputed income tax on subsidy amounts and should consult a tax advisor. Please contact Human Resources Department for more information.

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.

Summary of Benefits and Coverage

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

From:	Human Resources
Address:	50 Bald Eagle Drive Marco Island, FL 34145
Phone:	(239) 389-3970
Email:	lsanford@cityofmarcoisland.com
At Website URL:	www.cityofmarcoisland.com
BRC:	www.mybentek.com/cityofmarcoisland

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 at (239) 389-3970.

Medical Insurance

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

Medical Insurance – Cigna Open Access Plus Plan

24 Payroll Deductions – Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$56.74
Employee + Spouse/Domestic Partner	$126.20
Employee + Child(ren)	$106.27
Employee + Family	$174.60

Cigna | Customer Service: (866) 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 (866) 244-6224, or visit www.mycigna.com.

The myCigna Mobile App

The myCigna mobile app is an easy way to organize and access important health information. Anytime. Anywhere. Download it today from the App Store℠ or Google Play™. With the myCigna mobile app, members can• Quickly view, print, email, or share ID Cards from your mobile device

- Quickly view, print, email, or share ID Cards from your mobile device
- Search for a doctor, pharmacy, or health care facility, from Cigna's national network and compare quality-of-care ratings and costs
- View and search recent and past claims
- View and refill your prescriptions
- View plan coverage and authorizations
- Review plan deductibles and maximums
- View wellness goals and awards

And, much more!

Virgin Pulse, Offered Through Cigna

Virgin Pulse, offered through Cigna, provides health and well-being information and support through a behavior change system. This program is automatically included when employee enrolls in the medical plan. Through this program, employee can learn how to make more informed health care decisions, create a personalized action plan, and complete specific health actions. This intuitive program will engage employees in healthy lifestyle changes. With the Virgin Pulse app, members receive:

- Earn up to $100 in incentives
- Health Assessment
- Healthy Habits Tracking and Challenges
- Device and App Integration (Fitbit, Apple Health, Google Fit, Sleepio, etc.)
- Daily Content Cards (Wellness Informational Cards)
- Personalized Digital Health Coaching Journeys
- Employees may share access with up to 10 friends or family members at no additional cost

For more details regarding this program, please contact Cigna's customer service or visit www.mycigna.com.

Telehealth

Cigna provides access to telehealth services as part of the medical plan. MDLIVE is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is required and should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telehealth, such as:

- ✓ Mental Health
- ✓ Dermatology
- ✓ Sore Throat
- ✓ Headache
- ✓ Stomachache
- ✓ Fever
- ✓ Cold and Flu
- ✓ Allergies
- ✓ Rash
- ✓ Acne
- ✓ UTIs And More

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact MDLIVE through Cigna.

Cigna | MDLIVE | Customer Service: (888) 726-3171 | www.mycigna.com

Cigna Open Access Plus Plan At-A-Glance

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$500	$1,000
Family	$1,000	$2,000
Coinsurance		
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Limit		
Single	$2,500	$5,000
Family	$5,000	$10,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$20 Copay	30% After CYD
Specialist Office Visit	$40 Copay	30% After CYD
Virtual Visits *(through PCP)*	$20 Copay	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	No Charge	30% After CYD
X-rays	No Charge	30% After CYD
Advanced Imaging *(MRI, PET, CT)*	10% After CYD	30% After CYD
Outpatient Surgery in Surgical Center	10% After CYD	30% After CYD
Physician Services at Surgical Center	10% After CYD	30% After CYD
Urgent Care *(Per Visit)*	$50 Copay	30% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After CYD	30% After CYD
Outpatient Hospital *(Per Visit)*	10% After CYD	30% After CYD
Physician Services at Hospital	10% After CYD	30% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$150 Copay	$150 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After CYD	30% After CYD
Outpatient Services *(Per Visit)*	10% Coinsurance	30% After CYD
Outpatient Office Visit	$20 Copay	30% After CYD
Prescription Drugs *(Rx)*		
Generic	$10 Copay	50% Coinsurance
Preferred Brand	$35 Copay	50% Coinsurance
Non-Preferred Brand	$60 Copay	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	$25/$88/$150 Copay	Not Covered

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

Dental Insurance

The Standard Dental PPO Plan

The City offers dental insurance through The Standard 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 The Standard's customer service.

Dental Insurance – The Standard Dental PPO Plan

24 Payroll Deductions – Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$10.68
Employee + Spouse/Domestic Partner	$22.73
Employee + Child(ren)	$24.09
Employee + Family	$46.38

In-Network Benefits

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

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating The Standard Classic PPO provider. The Standard reimburses out-of-network services based on what it determines as the Usual & Customary Charge (U&C). The U&C 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 Standard's U&C and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

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

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the PPO plan will pay for each covered member is $1,500 for in-network and out-of-network services combined. All services, excluding preventive, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

Rollover Benefit

Max Builder allows employee to carryover part of the unused annual maximum. Employee earns dental rewards by submitting at least one (1) claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. Employee and covered dependent(s) may accumulate rewards up to the maximum carryover amount and use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member does not submit a dental claim during a benefit year, all accumulated rewards are lost for that year, but employees can begin earning rewards again the very next year. In addition, if employee stays in the PPO network they earn extra dental rewards called the PPO Bonus.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

The Standard | Customer Service: (800) 547-9515
www.standard.com/services

The Standard Dental PPO Plan At-A-Glance

Network	Classic (PPO)	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,500	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Calendar Year)*		
Fluoride Treatments *(Under Age 18, 2 Times Per Calendar Year)*		
Complete X-rays *(1 Every 5 Years)*		
Bitewing X-rays *(1 Per Calendar Year)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam & Composite)*	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Endodontics		
Periodontal Services		
Oral Surgery		
Anesthesia		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Dentures		
Bridges		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Dependent 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 The Standard's customer service or visit www.standard.com/services. When completing the necessary search criteria, select Classic (PPO) network.

Plan References

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

Important Notes

- *Each covered family member may receive up to two (2) routine cleanings per calendar year covered under the preventive benefit.*
- *For any 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.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services*

Vision Insurance

The Standard Vision Plan

The City offers vision insurance through The Standard 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 The Standard's customer service.

Vision Insurance – The Standard Vision Plan

24 Payroll Deductions – Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$2.68
Employee + Spouse/Domestic Partner	$4.96
Employee + Child(ren)	$5.02
Employee + Family	$9.02

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 Standard VSP Choice 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 The Standard VSP Choice network. When going out of network, the provider will require payment at the time of appointment. The Standard will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

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

The Standard

Customer Service: (800) 547-9515 | www.standard.com/services

The Standard Vision Plan At-A-Glance

Network	VSP Choice	
Services	**In-Network**	**Out-of-Network**
Eye Exam	$10 Copay	$10 Copay; Up to $45 Reimbursement
Contact Lens Exam *(Fit and Follow-up)*	Up to $60	Not Covered
Retinal Imaging	Up to $39	Not Covered
Frequency of Services*		
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses		
Single	No Charge	Up to $30 Reimbursement
Bifocal	No Charge	Up to $50 Reimbursement
Trifocal	No Charge	Up to $65 Reimbursement
Frames		
Allowance	Up to $150 Allowance; then 20% Discount Over Allowance	Up to $70 Reimbursement
Contact Lenses**		
Non-Elective *(Medically Necessary)*	No Charge	Up to $210 Reimbursement
Elective	Up to $150 Allowance	Up to $120 Reimbursement

Locate a Provider

To search for a participating provider, contact The Standard's customer service or visit www.standard.com/services. When completing the necessary search criteria, select VSP Choice network.

Plan References

**Frequencies are based on date of service*

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

Important Notes

- *Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.*

Flexible Spending Accounts

The City offers Flexible Spending Accounts (FSA) administered through Employee Benefits Corporation. The FSA plan year is from January 1 to December 31.

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 employee 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 two (2) types of FSAs:

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,050. 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 the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household.

Please Note: Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from participant's paycheck for the Dependent Care FSA.

A sample list of qualified Health Care 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

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

- The Health Care FSA allows a grace period at the end of the plan year from January 1 through March 15 (2 ½ months). The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends. Once the grace period ends, any unused funds still remaining in the account will be forfeited.
- The Health Care FSA has a run out period at the end of the plan year (90 days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year and/or grace period.
- When a plan year ends and all claims have been filed, all unused funds 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 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 online, by mail, fax, or through Employee Benefits Corporation mobile app. The IRS requires FSA participants 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. Employee Benefits Corporation 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 City. 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 $41.66 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	$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 a Health Care FSA, after a plan year or grace period ends and after all claims have been filed, cannot be returned or carried forward to the next plan year.* ***This rule is known as "use-it or lose-it."***

Claims Submission
Mailing Address: P.O. Box 44347, Madison, WI 53744
Fax: (608) 831-4790

Employee Benefits Corporation | Customer Service: (800) 346-2126
www.ebcflex.com

Employee Assistance Program

The City cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through HealthAdvocate. 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 offers covered employees and family members/domestic partners free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes three (3) 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 are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or Human Resources), 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. 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.

HealthAdvocate
Customer Service: (888) 293-6948
www.healthadvocate.com/standard3

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City offers Basic Term Life insurance for all eligible employees through The Standard. Eligible employees will receive a benefit amount of $50,000. The cost for this coverage is $14.00 a month, $7.00 per pay period, (if under age 65).

Accidental Death & Dismemberment Insurance

Included with the Basic Term Life Insurance is 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 50% of the benefit amount at age 70
- Reduces to 35% of the benefit amount at age 75

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

The Standard | Customer Service: (800) 628-8600 | www.standard.com

Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible employee may elect to purchase Voluntary Life insurance through The Standard. This coverage may be purchased in addition to the Basic Term Life and AD&D coverage. Voluntary Life insurance offers coverage for employee, spouse and/or child(ren) at different benefit levels. Employee must purchase Basic Term Life insurance in order to purchase Voluntary Life insurance for themselves or qualified dependents.

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 $80,000.**

- Units can be purchased in increments of $10,000 to a maximum of $300,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70
  - Reduces to 35% of the benefit amount at age 75
- Premium calculation:
  - Elected Coverage ÷ $1,000 x Employee Rate (see table to the right) = Monthly Premium.

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 $10,000.**

- Employee **must** participate in the Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $5,000, to a maximum of $150,000, not to exceed 50% of the employee's Voluntary Life coverage amount.
- Benefit amounts are subject to the following age reduction schedule (based on spouse age):
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70
  - Reduces to 35% of the benefit amount at age 75
- Premium calculation (based on the employee's age): Elected Coverage ÷ $1,000 x Spouse Rate (see table to the right) = Monthly Premium.

Voluntary Dependent Child(ren) Life Insurance

- Employee **must** participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- Coverage is $10,000 for eligible children. Late applications are subject to medical underwriting approval.
- Employees may cover their children from live birth through age 20 (24 if a registered full-time student).
- Cost for Dependent Child(ren) Life insurance is $1.00 a month regardless of the number of eligible children covered.

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

Voluntary Life Monthly Rates

Age Bracket *(Based on Employee Age)*	Employee/Spouse *Rate Per $1,000 of Benefit*
< 30	$0.08
30-34	$0.08
35-39	$0.10
40-44	$0.16
45-49	$0.26
50-54	$0.40
55-59	$0.54
60-64	$0.82
65-69	$1.38
70-74	$2.48
75+	$9.36

The Standard | Customer Service: (800) 628-8600 | www.standard.com

Voluntary Short Term Disability

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

Voluntary Short Term Disability (STD) Benefits

- STD provides a benefit of 60% of employee's weekly earnings up to a benefit maximum of $1,000 per week.
- Employee must be disabled for 29 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 30th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 180 days.
- Employee deemed unable to return to work after the STD 180 day maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefits may be reduced by other income.
- Disability benefits are taxable.
- Premium calculation (based on the employee's age): Weekly Earning x 0.60 x Rate (see table below) ÷ $10 = Monthly Premium. Weekly Earning cannot be more the $1,667.

Short Term Disability Monthly Rates

Age Bracket *(As of November 1st)*	Rate *(Per $10 of STD Benefit)*
< 30	$0.340
30-34	$0.380
35-39	$0.340
40-44	$0.360
45-49	$0.464
50-54	$0.556
55-59	$0.778
60+	$0.940

The Standard | Customer Service: (800) 368-2859 | www.standard.com

Voluntary Long Term Disability

The City offers Voluntary Long Term Disability (LTD) insurance to all eligible employees through The Standard. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Voluntary Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of $5,000 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits 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.
- Benefits may be reduced by other income.
- Benefits are payable to age 65 or are based on a reduced benefit duration if the employee is disabled on or after the age of 62.
- Cost for employee is $0.54 per $100 of monthly earnings.

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

Supplemental Insurance

Aflac

Aflac offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums are paid via payroll deduction. Aflac pays money directly to member, regardless of what other insurance plans they may have. Coverage is available for employee, spouse and children on most plans and the coverage is portable when employee retires or changes job with no increase in premiums. To learn more about these plans and/or to schedule a personal appointment, contact the local agent listed below. Details regarding the following available plans and services are also available online.

- ✓ Accident
- ✓ Hospital
- ✓ Critical Care
- ✓ Cancer

Aflac | Customer Service: (800) 992-3522 | www.aflac.com
Local Agent: Anna Wiseman | Cell: (239) 404-8894
Email: anna_wiseman@us.aflac.com

Travel Assistance Program

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

Pre-Trip Assistance: Currency exchange information, health hazards and inoculation requirements, passport, and visa information, and more.

Travel Assistance Services: Credit card and ticket replacement, passport and document replacement, emergency message service, missing baggage assistance, and more.

Medical Assistance Services: Locate medical care, translation, and interpretation services, and more.

Emergency Transportation Services: Emergency evacuation, medically necessary repatriation, return of dependent children, vehicle return, and more.

Personal Security Services: Security intelligence and evacuation services.

Travel Assistance | Customer Service: U.S., Canada, Puerto Rico,
U.S. Virgin Islands, and Bermuda: (800) 872-1414
All other locations worldwide: +1-609-986-1234 | Text: (609) 334-0807
Email: medservices@assistamerica.com | www.standard.com/travel
Reference Number: 01-AA-STD-5201

Claims, Billing & Benefit Assistance

If employees have questions on claims, receive bills from providers which they do not understand or would like general information on any of the employee benefits provided, please contact the Gehring Group Service Team.

The Gehring Group Service Team works directly with The City of Marco Island and its employees to provide claims and benefits service and will assist employees with their concerns. Please remember this is in addition to the Human Resources and is not replacing assistance employee may need from HR.

Employee may contact a claims specialist by:

1. Email: marcoisland@gehringgroup.com

Please include your name, contact information and a brief description of the issue. A Gehring Group Claims Specialist will respond via email or phone call to gather additional information.

OR

2. Call: (800) 244-3696

When calling, please identify yourself as an employee of the City of Marco Island and ask to speak to a Claims Specialist or another member of the City's designated team to assist with questions or concerns.

Office hours are Monday through Friday, 8:30am – 5:00pm. If calling after office hours, please leave a message indicating you are a City of Marco Island employee who would like to speak to a Claims Specialist. Please leave full name, contact information and a brief message and a Claims Specialist will be in contact with you the following business day.

At the Gehring Group, our goal is to be your advocate and ensure issues are resolved as quickly as possible.

RISK strategies | GEHRING GROUP
A RISK STRATEGIES COMPANY

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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