

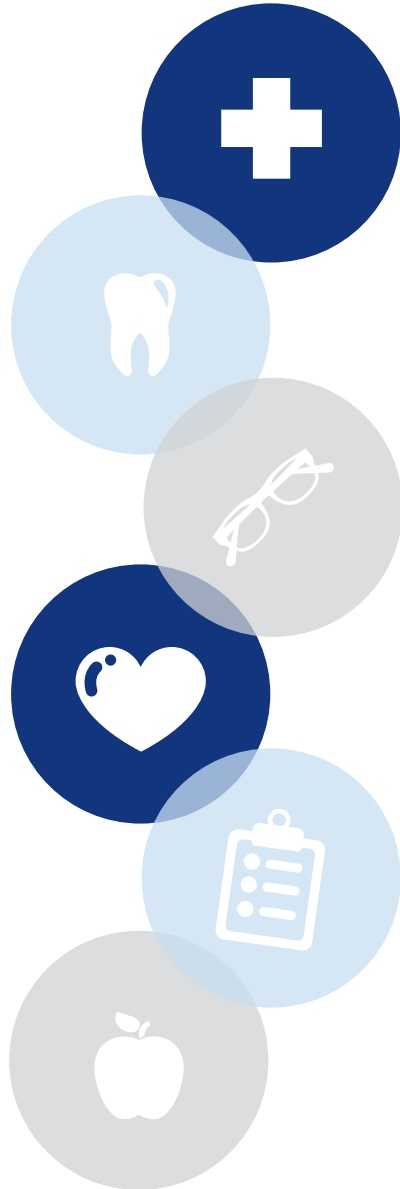
RIVIERA BEACH

2022 | 2023 EMPLOYEE BENEFIT HIGHLIGHTS





Table of Contents



Contact Information.....	1
Introduction.....	2
Online Benefit Enrollment.....	2
Group Insurance Eligibility.....	3-4
Qualifying Events and Section 125.....	4
Medical Insurance.....	5
Other Available Plan Resources.....	5
Telahealth.....	5
Summary of Benefits and Coverage.....	5
Aetna High Deductible with HRA Plan (City Sponsored) At-A-Glance.....	6
Aetna Buy-Up Option 1 Elect Choice \$750 Plan At-A-Glance.....	7
Aetna Buy-Up Option 2 Elect Choice \$1,000 Plan At-A-Glance.....	8
Dental Insurance.....	9
Solstice DHMO S100B Plan At-A-Glance.....	10
Dental Insurance.....	11
Solstice Dental PPO Plan At-A-Glance.....	12
Vision Insurance.....	13
Solstice Vision Plan At-A-Glance.....	14
Flexible Spending Accounts.....	15-16
Employee Assistance Program.....	17
Basic Life and AD&D Insurance.....	17
Voluntary Life and AD&D Insurance.....	18
Voluntary Short Term Disability.....	19
Voluntary Long Term Disability.....	19
Supplemental Insurance.....	19
Claims, Billing & Benefit Assistance.....	20
Notes.....	20

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 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 Department	Stephen Gude Benefits Manager	Phone: (561) 845-3408 Email: SGude@rivierabeach.org
	Steve Shields Risk Manager	Phone: (561) 840-4879 Email: SShields@rivierabeach.org
 Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) www.mybentek.com/rivierabch
 Medical Insurance	Aetna	Customer Service: (800) 445-5299 www.aetna.com
 Prescription Drug Coverage & Mail-Order Program	Aetna Rx Home Delivery	Customer Service: (866) 612-3862 www.aetna.com
 Telehealth	Teladoc	Customer Service: (855) 835-2362 member.teladoc.com/aetna
 Dental Insurance	Solstice	Customer Service: (877) 760-2247 www.solsticebenefits.com
 Vision Insurance	Solstice	Customer Service: (877) 760-2247 www.solsticebenefits.com
 Flexible Spending Accounts	PayFlex	Customer Service: (844) 729-3539 www.payflex.com
 Employee Assistance Program	Aetna Resources for Living	Customer Service: (888) 238-6232 www.resourcesforliving.com
 Basic Life and AD&D Insurance	Unum	Customer Service: (800) 275-8686 www.unum.com
	Voluntary Life and AD&D Insurance	Unum
 Voluntary Short Term Disability Insurance	Unum	Customer Service: (800) 275-8686 www.unum.com
	Voluntary Long Term Disability Insurance	Unum
 Supplemental Insurance	Aflac	Agent: Jewel Sands Phone: (772) 631-8192 Email: jewel_sands@us.aflac.com Customer Service: (800) 992-3522 www.aflac.com
 Claims, Billing & Benefit Assistance	Gehring Group	Customer Service: (800) 244-3696 Email: rivierabeach@gehringgroup.com



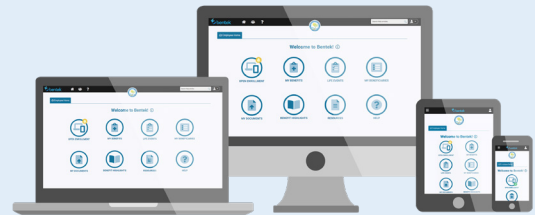
Introduction

The City of Riviera 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 City Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If you require further explanation or need assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact the Human Resources Department.

Online Benefit Enrollment

The City of Riviera Beach 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/rivierabch
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 October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first day of employment with the exception of Life Insurance, Short Term Disability (STD) and Long Term Disability (LTD). Coverage for these benefits will be effective the first of the month following 60 days of employment..

Separation of Employment

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

Dependent Eligibility

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

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to the age of 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the 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 child turns age 30.

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

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

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 the Human Resources Department 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 the Human Resources Department 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, **the Human Resources Department must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes may be effective the date of the Qualifying Event or the first of the month following the Qualifying Event. Newborns are effective on the date of birth. Qualifying Events will be processed in accordance with employer and carrier eligibility policy. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements.



Medical Insurance

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

Medical Insurance

Aetna High Deductible with HRA Plan (City Sponsored)

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$0
Employee + 1	\$215.89
Employee + Family	\$313.01

Medical Insurance

Aetna Buy-Up Option 1 Elect Choice \$750 Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$84.87
Employee + 1	\$334.70
Employee + Family	\$447.11

Medical Insurance

Aetna Buy-Up Option 2 Elect Choice \$1,000 Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$192.93
Employee + 1	\$486.20
Employee + Family	\$617.22

Aetna | Customer Service: (800) 445-5299 | www.aetna.com

Summary of Benefits and Coverage

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

From: Human Resources Department
Address: 1481 W 15th St.
 Riviera Beach, FL 33404
Phone: (561) 840-4880
Website URL: www.mybentek.com/rivierabch

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

If there are any questions about the plan offerings or coverage options, please contact the Human Resources Department at (561) 840-4880.

Other Available Plan Resources

Aetna offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please contact Aetna's customer service at (800) 445-5299, or visit www.aetna.com.

Telehealth

Aetna provides access to telehealth services as part of the medical plan. Teladoc 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:

- ✓ 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 Teladoc.

Teladoc | Customer Service: (855) 835-2362 | www.teladoc.com/aetna



Aetna High Deductible with HRA Plan (City Sponsored) At-A-Glance

Network	Elect Choice EPO
Plan Year Deductible (PYD)	
Single	In-Network \$2,500
Family	\$5,000
Coinsurance	
Member Responsibility	20%
Plan Year Out-of-Pocket Limit	
Single	\$4,000
Family	\$8,000
What Applies to the Out-of-Pocket Limit?	Coinsurance, Deductible, Copays and Rx
Physician Services	
Primary Care Physician (PCP) Office Visit	20% After PYD
Specialist Office Visit	20% After PYD
Telehealth Services	20% After PYD
Non-Hospital Services; Freestanding Facility	
Clinical Lab (Bloodwork)*	20% After PYD
X-rays	20% After PYD
Advanced Imaging (MRI, PET, CT)	20% After PYD
Outpatient Surgery in Surgical Center	20% After PYD
Physician Services at Surgical Center	20% After PYD
Urgent Care (Per Visit)	20% After PYD
Hospital Services	
Inpatient Hospital (Per Admission)	20% After PYD
Outpatient Hospital (Per Visit)	20% After PYD
Physician Services at Hospital	20% After PYD
Emergency Room (Per Visit)	20% After PYD
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services (Per Admission)	20% After PYD
Outpatient Services (Per Visit)	20% After PYD
Outpatient Office Visit	20% After PYD
Prescription Drugs (Rx)	
Generic	\$5 Copay After PYD
Preferred Brand Name	\$35 Copay After PYD
Non-Preferred Brand Name	\$75 Copay After PYD
Mail Order Drug (90-Day Supply)	2x Retail Copay After PYD



The Aetna High Deductible with HRA Plan deductible and out-of-pocket maximum run on the plan year, October 1 through September 30.



Locate a Provider

To search for a participating provider, contact Aetna's customer service or visit www.aetna.com. When completing the necessary search criteria, select Aetna's Elect Choice EPO network.



Plan References

*Quest Diagnostics is the preferred lab for bloodwork through Aetna. When using a lab other than Quest, please confirm they are contracted with Aetna's Elect Choice EPO network prior to receiving services.



Important Notes

Services received by providers or facilities not in the Elect Choice EPO network, will not be covered.



Aetna Buy-Up Option 1 Elect Choice \$750 Plan At-A-Glance



The Aetna Buy-Up Option 1 Elect Choice \$750 Plan deductible and out-of-pocket maximum run on the calendar year, January 1 through December 31.



Locate a Provider

To search for a participating provider, contact Aetna's customer service or visit www.aetna.com. When completing the necessary search criteria, select Aetna's Elect Choice EPO network.



Plan References

*Quest Diagnostics is the preferred lab for bloodwork through Aetna. When using a lab other than Quest, please confirm they are contracted with Aetna's Elect Choice EPO network prior to receiving services.



Important Notes

Services received by providers or facilities **not** in the Elect Choice EPO network, will not be covered.

Network	Elect Choice EPO
Calendar Year Deductible (CYD)	
Single	\$750
Family	\$1,500
Coinsurance	
Member Responsibility	0%
Calendar Year Out-of-Pocket Limit	
Single	\$3,000
Family	\$6,000
What Applies to the Out-of-Pocket Limit?	Coinsurance, Deductible, Copays and Rx
Physician Services	
Primary Care Physician (PCP) Office Visit	\$15 Copay
Specialist Office Visit	\$35 Copay
Telehealth Services	\$15 Copay (Primary Care) / \$35 Copay (Specialist)
Non-Hospital Services; Freestanding Facility	
Clinical Lab (Bloodwork)*	No Charge
X-rays	\$30 Copay
Advanced Imaging (MRI, PET, CT)	No Charge After CYD
Outpatient Surgery in Surgical Center	No Charge After CYD
Physician Services at Surgical Center	No Charge After CYD
Urgent Care (Per Visit)	\$30 Copay
Hospital Services	
Inpatient Hospital (Per Admission)	\$400 Copay After CYD
Outpatient Hospital (Per Visit)	No Charge After CYD
Physician Services at Hospital	No Charge After CYD
Emergency Room (Per Visit; Waived if Admitted)	\$250 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services (Per Admission)	\$400 Copay After CYD
Outpatient Services (Per Visit)	No Charge
Outpatient Office Visit	\$35 Copay
Prescription Drugs (Rx)	
Generic	\$5 Copay
Preferred Brand Name	\$35 Copay
Non-Preferred Brand Name	\$75 Copay
Mail Order Drug (90-Day Supply)	2x Retail Copay



Aetna Buy-Up Option 2 Elect Choice \$1,000 Plan At-A-Glance

Network	Elect Choice EPO
Calendar Year Deductible (CYD)	
Single	\$1,000
Family	\$3,000
Coinsurance	
Member Responsibility	20%
Calendar Year Out-of-Pocket Limit	
Single	\$3,000
Family	\$9,000
What Applies to the Out-of-Pocket Limit?	Coinsurance, Deductible, Copays and Rx
Physician Services	
Primary Care Physician (PCP) Office Visit	\$25 Copay
Specialist Office Visit	\$45 Copay
Telehealth Services	\$25 Copay (Primary Care) / \$45 Copay (Specialist)
Non-Hospital Services; Freestanding Facility	
Clinical Lab (Bloodwork)*	20% After CYD
X-rays	20% After CYD
Advanced Imaging (MRI, PET, CT)	20% After CYD
Outpatient Surgery in Surgical Center	20% After CYD
Physician Services at Surgical Center	20% After CYD
Urgent Care (Per Visit)	\$50 Copay
Hospital Services	
Inpatient Hospital (Per Admission)	20% After CYD
Outpatient Hospital (Per Visit)	20% After CYD
Physician Services at Hospital	20% After CYD
Emergency Room (Per Visit)	\$150 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services (Per Admission)	20% After CYD
Outpatient Services (Per Visit)	No Charge
Outpatient Office Visit	\$45 Copay
Prescription Drugs (Rx)	
Generic	\$5 Copay
Preferred Brand Name	\$35 Copay
Non-Preferred Brand Name	\$75 Copay
Mail Order Drug (90-Day Supply)	2x Retail Copay



The Aetna Buy-Up Option 2 Elect Choice \$1,000 Plan deductible and out-of-pocket maximum run on the calendar year, January 1 through December 31.



Locate a Provider

To search for a participating provider, contact Aetna's customer service or visit www.aetna.com. When completing the necessary search criteria, select Aetna's Elect Choice EPO network.



Plan References

*Quest Diagnostics is the preferred lab for bloodwork through Aetna. When using a lab other than Quest, please confirm they are contracted with Aetna's Elect Choice EPO network prior to receiving services.



Important Notes

Services received by providers or facilities **not** in the Elect Choice EPO network, will not be covered.



Dental Insurance

Solstice DHMO S100B Plan

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

Dental Insurance – Solstice DHMO S100B Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$0
Employee + Family	\$8.87

In-Network Benefits

The DHMO S100B 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 Solstice DHMO S100B network to receive covered services. There is no coverage for services received out-of-network.

The DHMO S100B 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 S100B plan does not cover any services rendered by out-of-network facilities or providers.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Benefit Maximum

There is no benefit maximum.

IMPORTANT NOTES



- Each covered family member may receive up to one (1) routine cleaning every six (6) months covered under the preventive benefit. Members can also receive additional cleanings at the charge of a \$15 copay.
- Prior authorization is not required for specialty referrals for Endodontic, Orthodontic and Pediatric Services.
- Waiting periods and age limitations may apply.

Solstice | Customer Service: (877) 760-2247 | www.solsticebenefits.com



Solstice DHMO S100B Plan At-A-Glance

Network	S100B
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Calendar Year Deductible (CYD)	In-Network
Per Member	Does Not Apply
Per Family	
Waived for Class I Services?	

Calendar Year Benefit Maximum	In-Network
Per Member	Does Not Apply

Class I Services: Diagnostic & Preventive Care	Code	In-Network
Routine Oral Exam (1 Every 6 Months)	0150	\$0 Copay
Routine Cleanings (1 Every 6 Months)	1110	
Bitewing X-rays (1 Set Every 12 Months)	0272	
Complete X-rays (1 Every 5 Years)	0210	

Class II Services: Basic Restorative Care	Code	In-Network
Fillings (Amalgam, 3 Surface)	2160	\$0 Copay
Fillings (Resin, 3 Surface Posterior)	2393	\$0 Copay
Simple Extractions (Erupted Tooth or Exposed Root)	7140	\$10 Copay
Root Canal Therapy (Molar)*	3330	\$210 Copay
Surgical Removal of Tooth (Impacted)	7240	\$63 Copay
Full Mouth Debridement	4341	\$36 Copay

Class III Services: Major Restorative Care	Code	In-Network
Crowns (Porcelain Fused to Metal)**	2752	\$195 Copay + Lab
Bridges**	5213	\$220 Copay + Lab
Dentures	5110/20	\$210 Copay + Lab

Class IV Services: Orthodontia	Code	In-Network
Benefit - Child	8080	\$1,850 Copay
Benefit - Adult	8090	\$1,950 Copay
Treatment Planning/Records	8660	\$35 Copay
Retention	8680	\$300 Copay



Locate a Provider

To search for a participating provider, contact Solstice's customer service or visit www.solsticebenefits.com. When completing the necessary search criteria, select S100B network.



Plan References

* Excluding final restoration

**Copay does not include the cost of precious (high noble) and semi-precious (noble) metal. The additional cost of precious metal shall not exceed \$145 per unit and \$120 per unit for semi-precious metal.



Dental Insurance

Solstice Dental PPO Plan

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

Dental Insurance – Solstice Dental PPO Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$7.66
Employee + Family	\$33.29

In-Network Benefits

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

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Solstice Dental PPO provider. Solstice 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 Solstice'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.

Calendar Year Deductible

There is no Calendar Year Deductible.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the Dental PPO plan will pay for each covered member is \$5,000 for in-network and out-of-network services combined. Diagnostic and preventive services do not 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.

Solstice | Customer Service: (877) 760-2247 | www.solsticebenefits.com



Solstice Dental PPO Plan At-A-Glance

Network	Solstice PPO	
	In-Network	Out-of-Network*
Calendar Year Deductible (CYD)		
Per Member		\$0
Per Family		\$0
Waived for Class I Services?		N/A
Calendar Year Benefit Maximum		
Per Member		\$5,000
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam (2 Per Year)	Plan Pays: 100%	Plan Pays: 100% (Subject to Balance Billing)
Routine Cleanings (4 Per Year)		
Complete X-rays (1 Every 3 Years)		
Bitewing X-rays (1 Set Per Year)		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80%	Plan Pays: 80% (Subject to Balance Billing)
Simple Extractions		
Oral Surgery		
Periodontal Services		
Anesthetics		
Endodontics (Root Canal Therapy)		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum		\$1,000
Benefit	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)



Locate a Provider

To search for a participating provider, contact Solstice's customer service or visit www.solsticebenefits.com. When completing the necessary search criteria, select Solstice 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 four (4) routine cleanings per calendar year covered under the preventive benefit.
- For any dental work expected to cost \$300 or more, the plan will provide a "Pre-Treatment Estimate" 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

Solstice Vision Plan

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

Vision Insurance - Solstice Vision Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$2.45
Employee + Family	\$6.62

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 Solstice Clear 90 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 Solstice Clear 90 network. When going out of network, the provider will require payment at the time of appointment. Solstice 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.

Solstice | Customer Service: (877) 760-2247 | www.solsticebenefits.com



Solstice Vision Plan At-A-Glance

Network		Clear 90	
Services	In-Network	Out-of-Network	
Eye Exam	\$4 Copay	Up to \$30 Reimbursement	
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		12 Months	
Contact Lenses		12 Months	
Lenses			
Single	\$10 Copay	Up to \$25 Reimbursement	
Bifocal	\$10 Copay	Up to \$35 Reimbursement	
Trifocal	\$10 Copay	Up to \$45 Reimbursement	
Frames			
Allowance	Up to \$120 Allowance	Up to \$30 Reimbursement	
Contact Lenses*			
Elective (<i>Fitting, Follow-up & Lenses</i>)	Up to \$110 Allowance	Up to \$85 Reimbursement	
Non-Elective (<i>Medically Necessary, Prior Authorization Required</i>)	No Charge	Up to \$150 Reimbursement	



Locate a Provider

To search for a participating provider, contact Solstice's customer service or visit www.solsticebenefits.com. When completing the necessary search criteria, select Clear 90 network.



Plan References

*Contact lenses are in lieu of spectacle lenses.



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 PayFlex. The FSA plan year is from January 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 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 \$2,850. 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 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 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

- Employee may carry over any 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.
- Employee can enroll in an FSA only during the Open Enrollment Period, New Hire Orientation or for Qualifying Life Events.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services 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 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. PayFlex 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.

PayFlex | Phone: (844) 729-3539 | www.payflex.com

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	



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 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 offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes six (6) face-to-face 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 the Human Resources Department, we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring manager. The referring manager will not receive specific information regarding the referred employee's case. The manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Aetna Resources for Living

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

Username: Rivierabch | Password: eap

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides Basic Term Life insurance for all eligible employees at no cost, through Unum. Eligible employees will receive a benefit amount of \$40,000.

Accidental Death & Dismemberment Insurance

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

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- > Reduces to 65% of the benefit amount at age 65
- > Reduces to 50% of the benefit amount at age 70

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

Unum | Customer Service: (800) 275-8686 | www.unum.com



Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

Eligible employee may elect to purchase additional Life and AD&D insurance on a voluntary basis through Unum. 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.

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 \$200,000.**

- Units can be purchased in increments of \$10,000 to the maximum of \$500,000.
- Benefit amounts are subject to the following age reduction schedule:
 - › Reduces to 65% of the benefit amount at age 70
 - › Reduces to 50% of the benefit amount at age 75

Voluntary Spouse Life and AD&D 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 \$30,000.**

- 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 \$500,000 not to exceed 100% of the employee's Voluntary Life coverage amount.
- Benefit amounts are subject to the following age reduction schedule:
 - › Reduces to 65% of the benefit amount at age 70
 - › Reduces to 50% of the benefit amount at age 75

Voluntary Life and AD&D Insurance Rate Table

Monthly Premium

Age Bracket	Employee/Spouse (Rate Per \$1,000 of Benefit)
15-24	\$0.074
25-29	\$0.081
30-34	\$0.109
35-39	\$0.162
40-44	\$0.246
45-49	\$0.384
50-54	\$0.567
55-59	\$0.811
60-64	\$1.043
65-69	\$1.483
70-74	\$2.806
>75	\$8.674
Employee AD&D	\$0.064
Spouse AD&D	\$0.067
Child(ren) Life Rate	\$0.341
Child(ren) AD&D	\$0.034

Voluntary Dependent Child(ren) Life and AD&D Insurance

- Employee must participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- Employee may elect coverage in the following amounts: Coverage for Child(ren) age 14 days to six (6) months \$1,000.
- Coverage for Child(ren) age six (6) months to 19 (26, if full-time student) can be purchased in increments of \$2,000 to a maximum of \$10,000.

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

Unum | Customer Service: (800) 275-8686 | www.unum.com



Voluntary Short Term Disability

The City offers Voluntary Short Term Disability (STD) insurance to all eligible employees through Unum. 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 \$1,250 per week.
- Employee must be disabled for 14 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 15th day after the employee is disabled due to non-work related injury or illness.
- The maximum benefit period is 11 weeks.
- Employee deemed unable to return to work after the STD 11 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefits may be reduced by other income.
- Disability benefits may be taxable.

Unum | Customer Service: (800) 275-8686 | www.unum.com

Voluntary Long Term Disability

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

Voluntary Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of \$6,000 per month.
- Employee must be disabled for 90 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 91st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.
- Disability benefits may be taxable.

Unum | Customer Service: (800) 275-8686 | www.unum.com

Voluntary STD and LTD Rate Table

Age Bracket	Voluntary STD (Rate Per \$10 of Weekly Benefit)	Voluntary LTD (Rate Per \$100 of Weekly Benefit)
< 25	\$0.370	\$0.300
25-29	\$0.400	\$0.350
30-34	\$0.370	\$0.490
35-39	\$0.360	\$0.790
40-44	\$0.380	\$1.000
45-49	\$0.410	\$1.400
50-54	\$0.480	\$1.920
55-59	\$0.620	\$2.170
60-64	\$0.760	\$2.050
65-69	\$0.840	\$1.500
70 +	\$0.840	\$1.320

Supplemental Insurance

Aflac

Aflac offers a variety of supplemental insurance plans that may be purchased by employee and premiums paid by payroll deduction. Aflac pays money directly to employee, regardless of what other insurance plans the employee may have. Available Aflac plans include:

- ✓ Accident Indemnity Advantage
- ✓ Cancer Protection Assurance
- ✓ Critical Care and Recovery
- ✓ Hospital Choice

Newly hired employees are able to enroll for this coverage on a pre-tax basis. Employees who do not enroll for Aflac when initially hired or during Open Enrollment will be enrolled on a post-tax basis.

To learn more about these Aflac plans, determine eligibility, discuss policies not listed or other available options, employee can request a personal appointment with the Aflac Agent, Jewel Sands.

Agent: Jewel Sands | Phone: (772) 631-8192

Email: jewel_sands@us.aflac.com

Aflac | Customer Service: (800) 992-3522

Claims Fax: (877) 442-3522 | www.aflac.com



Q & A

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 Riviera Beach and its employees to provide claims and benefits service and will assist employees with their concerns. Please remember this is in addition to the City's Human Resources Department and is not replacing assistance employee may need from the Human Resources Department.

Employee may contact a claims specialist by:

1. Email: rivierabeach@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 Riviera Beach and ask to speak to a Claims Specialist or another member of the City of Riviera Beach'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 Riviera Beach 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.

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.



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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