2023 | 2024

Employee Benefit Highlights

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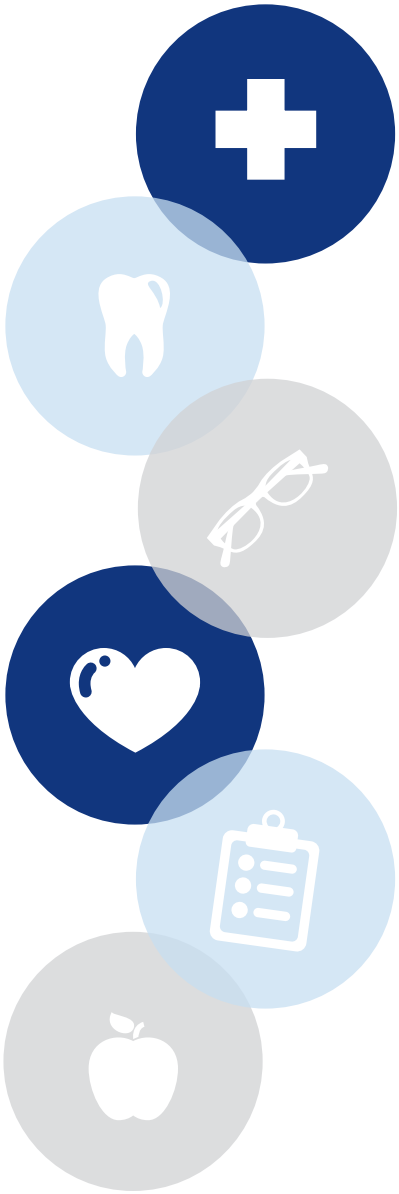


This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City reserves the right to amend, modify or terminate the plan at any time. This booklet should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

Contact Information

	Human Resources Department	Stephen Gude Benefits Manager	Phone: (561) 840-4880 Email: SGude@rivierabeach.org
		Jacqueline Bartley Human Resources Director	Phone: (561) 840-4880 Email: JBartley@rivierabeach.org
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) Email: support@mybentek.com www.mybentek.com/rivierabch
	Medical Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Cigna/Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
	Telehealth	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.mycigna.com
	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	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Employee Assistance Program	Cigna	Customer Service: (877) 622-4327 www.mycigna.com
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Voluntary Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Voluntary Short Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Voluntary Long Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Supplemental Insurance	Aflac	Agent: Jewel Sands | Phone: (772) 631-8192 www.aflac.com
		Cigna	Customer Service: (800) 754-3207 www.mycigna.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.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plans 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

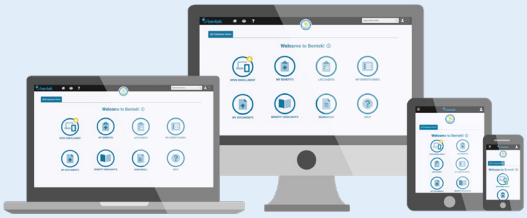
The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Human Resources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

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

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 Events.

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



To Access the Employee Benefits Center:

- ✓ Log on to **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 of the month following date of hire. For example, if an employee is hired in April 11, then the effective date of coverage will be May 1.

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 (FloridaState Statute)
- 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.

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 Cigna Healthcare 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 pages. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Cigna's customer service.

Medical Insurance - Cigna Choice High Deductible with HRA Plan (City Sponsored)

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + 1	$234.90
Employee + Family	$340.55

Medical Insurance - Cigna Open Access Plus Buy-Up Option 1 ($750) Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$92.75
Employee + 1	$364.82
Employee + Family	$487.24

Medical Insurance - Cigna Open Access Plus Buy-Up Option 2 ($1,000) Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$211.86
Employee + 1	$533.10
Employee + Family	$677.65

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

Medical Plan Resources

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

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:

- ✓ Sore Throat
- ✓ Fever
- ✓ Rash
- ✓ Headache
- ✓ Cold and Flu
- ✓ Acne
- ✓ Stomachache
- ✓ Allergies
- ✓ 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.

Medical Plan	Urgent Care	Primary Care	Specialty Care
Cigna Choice High Deductible with HRA Plan	20% After PYD	20% After PYD	20% After PYD
Cigna Open Access Plus Buy-Up Option 1	$15 Copay	$15 Copay	$35 Copay
Cigna Open Access Plus Buy-Up Option 2	$25 Copay	$25 Copay	$45 Copay

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

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

Network	Open Access Plus
Plan Year Deductible (PYD)	**In-Network**
Single	$2,500
Family	Per Person: $2,500 | Per Family: $5,000
Coinsurance	
Member Responsibility	20%
Plan Year Out-of-Pocket Limit	
Single	$4,000
Family	Per Person: $4,000 | Per 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
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 Cigna Choice 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 Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Cigna's Open Access Plus network.

Plan References

**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.*

Important Notes

- *Services received by providers or facilities **not** in the Open Access Plus network, will not be covered.*
- *The Cigna Choice High Deductible with HRA plan provides funding to use for member's in-network deductible and coinsurance. Members with single coverage receive $500; members with family coverage receive $1,000 in HRA funds. Any remaining funds at the end of the plan year will roll over into the next plan year.*

Cigna Open Access Plus Buy-Up Option 1 ($750) Plan At-A-Glance

The Cigna Open Access Plus Buy-Up Option 1 ($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 Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Cigna's Open Access Plus network.

Plan References

**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.*

Important Notes

*Services received by providers or facilities **not** in the Open Access Plus network, will not be covered.*

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	$750
Family	$1,500
Coinsurance	
Member Responsibility	0%
Calendar Year Out-of-Pocket Limit	
Single	$3,000
Family	Per Person: $3,000 | Per 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
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)**	No Charge
X-rays	No Charge
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

Cigna Open Access Plus Buy-Up Option 2 ($1,000) Plan At-A-Glance

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	$1,000
Family	$3,000
Coinsurance	
Member Responsibility	20%
Calendar Year Out-of-Pocket Limit	
Single	$3,000
Family	Per Person: $3,000 | Per 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
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; Waived If Admitted)*	$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 Cigna Open Access Plus Buy-Up Option 2 ($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 Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Cigna's Open Access Plus network.

Plan References

**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.*

Important Notes

*Services received by providers or facilities **not** in the Open Access Plus network, will not be covered.*

Dental Insurance

Solstice DHMO S100B Access + 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 Access + 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 Access + plan provides benefits for services received from in-network and out-of-network providers. Employee and dependent(s) may select any participating dentist in the Solstice DHMO S100B network to receive covered services.

The DHMO S100B Access + 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

Out-of-network benefits are used when member receives services by a non-participating Solstice S100B provider. Solstice reimburses out-of-network services based on certain services listed in the plans Schedule of Benefits. 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 Benefit Maximum

There is no benefit maximum.

IMPORTANT NOTES

- *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 Access + Plan At-A-Glance

Network	S100B	
Calendar Year Deductible (CYD)	**In-Network**	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Calendar Year Benefit Maximum		
Per Member	Does Not Apply	
Class I Services: Diagnostic & Preventive Care	**Code**	**In-Network**
Routine Oral Exam *(1 Every 6 Months)*	0150	No Charge
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		
Fillings *(Amalgam, 3 Surface)*	2160	No Charge
Fillings *(Resin, 3 Surface Posterior)*	2393	No Charge
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		
Crowns *(Porcelain Fused to Metal)***	2752	$195 Copay + Lab
Bridges **	5213	$220 Copay + Lab
Dentures	5110/20	$210 Copay + Lab
Class IV Services: Orthodontia		
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 network. 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	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
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

- *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 *(Fitting, Follow-up & Lenses)*	Up to $110 Allowance	Up to $85 Reimbursement
Non-Elective *(Medically Necessary, Prior Authorization Required)*	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 Cigna. The FSA plan year is from October 1 to September 30.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows 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 $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 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

- Employee may carry over up to $610 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed (only if the employee re-enrolls the next year). Dependent Care funds cannot be carried over.
- The Health Care FSA has a 90 day run out period at the end of the plan year to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year.
- Employee can enroll in an FSA only during the Open Enrollment Period, New Hire Orientation or Qualifying Events.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible in the employee FSA as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA 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.

Mobile App

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

- ✓ Request reimbursement
- ✓ Send payment
- ✓ Scan item for eligibility
- ✓ Manage expenses
- ✓ View and upload receipts

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 an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the $610 carry over that may be allowed for the Health Care FSA.* ***This rule is known as "use-it or lose-it."***

Cigna | Phone: (800) 244-6224 | www.mycigna.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 Cigna. 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) visits with a specialist, per person, per issue, per year, online material/tools and webinars. EAP offers counseling services on issues such as:

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

Are Services Confidential?

Yes. Receipt of EAP services 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.

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

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 New York Life Group Benefit Solutions. 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.

New York Life Group Benefit Solutions
Customer Service: (800) 362-4462 | www.mynylgbs.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 New York Life Group Benefit Solutions. This coverage may be purchased in addition to the Basic Term Life and AD&D coverage. Voluntary Life insurance offers coverage for employee, spouse and/or dependent child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life and AD&D 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, not to exceed ten (10) times annual salary.
- 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

2023 Open Enrollment: Employees may enroll or increase coverage up to but not exceeding the Guaranteed Issue amount of $200,000 without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). All others will need to complete an EOI. Please contact Human Resources for additional information.

Voluntary Spouse Life and AD&D Insurance

New Hires may purchase Voluntary Spouse Life and AD&D 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.
- Spouse coverage terminates at age 70.
- 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

2023 Open Enrollment: Employees may enroll or increase coverage for spouses up to but not exceeding the Guaranteed Issue amount of $30,000 without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). All others will need to complete an EOI. Please contact Human Resources for additional information.

Voluntary Life and AD&D Insurance Rate Table

Monthly Premium

Age Bracket	Employee/Spouse *(Rate Per $1,000 of Benefit)*
<25	$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

Please Note: Spouse coverage terminates when spouse reaches age 70.

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

- Employee must participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- Coverage may be purchased for dependent child(ren) birth to six (6) months in the amount of $1,000.
- Coverage may be purchased for dependent child(ren) age six (6) months up to the date in which the dependent child reaches age 26 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.

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

Voluntary Short Term Disability

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

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.

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

Voluntary Long Term Disability

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

New York Life Group Benefit Solutions
Customer Service: (800) 362-4462 | www.mynylgbs.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	$0.240
25-29	$0.400	$0.280
30-34	$0.370	$0.390
35-39	$0.360	$0.630
40-44	$0.380	$0.800
45-49	$0.410	$1.120
50-54	$0.480	$1.540
55-59	$0.620	$1.740
60-64	$0.760	$1.640
65-69	$0.840	$1.200
70 +	$0.840	$1.060

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

Supplemental Insurance *(Continued)*

The City offers supplemental insurance plans through Cigna and plans may be selected online through Bentek and paid by payroll deductions. Cigna's Accidental Injury, Critical Illness and Hospital Care insurance provide additional financial protection for the unexpected. Benefits are paid directly to the covered person for a covered critical illness, accident, injury or hospitalization, based on plan. The money can be used for expenses such as:

- Paying for child care or assistance in the home
- Travel costs for treatments or specialist/doctor visits
- Copays and deductibles
- Prescription drug costs
- Lost wages
- Rehabilitations and therapy expenses

Accidental Injury Insurance

Accidental Injury coverage provides a benefit when a covered person suffers covered injuries or undergoes a broad range of medical treatments or care resulting from a covered accident. Benefit amounts are paid regardless of actual expenses incurred from the covered injury. A brief summary of benefits is provided below. For more detailed information about the plan, please refer to the Cigna Summary of Benefits document or contact Cigna's customer service.

Plan At-A-Glance

Initial & Emergency Care	Benefit Amounts
Ground Ambulance/Air Ambulance	$400/$1,600
Emergency Care Treatment	$200
Diagnostic Exam *(X-ray Or Lab)*	$75
Physician Office Visit	$100
Hospitalization Benefits	**Benefit Amounts**
Hospital Admission	$1,000
Hospital Stay *(Per Day)*	$200
Intensive Care Unit Stay *(Per Day)*	$400
Fractures and Dislocations	**Benefit Amounts**
Per Covered Surgically-Repaired Fracture	$200 - $8,000
Per Covered Non-Surgically-Repaired Fracture	$100 - $4,000
Per Covered Surgically-Repaired Dislocation	$200 - $8,000
Per Covered Non-Surgically-Repaired Dislocation	$100 - $4,000
Follow-Up Care	**Benefit Amounts**
Follow-Up Visit To The Doctor	$75
Follow-Up Physical Therapy Visits	$50
Preventive Care Benefit	**Benefit Amounts**
Wellness Health Screening	$75
Accidental Death Benefit	**Benefit Amounts**
Loss of Life	$50,000
Automobile Death	$100,000

Hospital Care Insurance

Hospital Care coverage provides a benefit according to the schedule below when a covered person incurs a hospital stay resulting from a covered injury or covered illness. A brief summary of benefits is provided below. For more detailed information about the plan, please refer to the Cigna Summary of Benefits document or contact Cigna's customer service.

Plan At-A-Glance

Hospitalization Benefits	Benefit Amounts
Hospital Admission Limited to 1 Benefit Every 365 Days	$1,000
Hospital Chronic Condition Admission Limited to 1 Benefit Every 90 Days	$50
Hospital Stay Limited to 30 days, 1 Benefit Every 90 Days	$100 Per Day
Hospital Intensive Care Unit (ICU) Stay Limited to 30 days, 1 Benefit Every 90 Days	$200 Per Day
Hospital Observation Stay 24 Hour Elimination Period. Limited to 72 Hours.	$100 Per Day
Additional Benefits	**Benefit Amounts**
Wellness Health Screening	$50 Per Year

Cigna | Phone: (800) 754-3207 | www.mycigna.com

Supplemental Insurance *(Continued)*

Critical Illness Plan

Critical Illness Insurance provides a lump sum of benefit when a covered person is diagnosed with a covered critical illness or event after coverage is in effect. A brief summary of benefits is provided below. For more detailed information about the plan, please refer to the Cigna Summary of Benefits document or contact Cigna's customer service.

Benefit Amounts

	Benefit Amount	Guaranteed Issue Amount
Employee	$20,000	$20,000
Spouse	$20,000	$20,000
Child(ren)	$20,000	$20,000

Plan At-A-Glance

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Cancer Conditions		
Skin Cancer *(1x Per Lifetime)*	$250	N/A
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
Vascular Conditions		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
Health Screening Test		
Wellness Treatment, Health Screening and Preventive Care	$50 per year	

Cigna | Phone: (800) 754-3207 | www.mycigna.com

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.

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RISK strategies | GEHRING GROUP
A RISK STRATEGIES COMPANY

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