CITY OF MARGATE
Together We Make It Great

CITY OF MARGATE

2021 | EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

	Human Resources Director	Laurie Meyer	Phone: (954) 935-5343 Email: lmeyer@margatefl.com
	Human Resources Generalist	Omaine Dennis	Phone: (954) 935-5272 Email: odennis@margatefl.com
	Human Resources Specialist	Shyanne Saintvil	Phone: (954) 935-5270 Email: ssaintvil@margatefl.com
	Risk Manager	Laura Pastore	Phone: (954) 935-5271 Email: lpastore@margatefl.com
	Risk Management Specialist	Paul Addotta	Phone: (954) 935-5275 Email: paddotta@margatefl.com
	Payroll & Benefits Supervisor	Leslie Russell	Phone: (954) 935-5386 Email: lrussell@margatefl.com
	Payroll & Benefits Specialist	Sabrina Agostino	Phone: (954) 935-5345 Email: sagostino@margatefl.com
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) Email: support@mybentek.com www.mybentek.com/cityofmargate
	Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Cigna Home Delivery	Customer Service: (800) 835-3784 www.mycigna.com
	Telehealth	Cigna MDLIVE	Customer Service: (888) 726-3171 www.MDLIVEforCigna.com Customer Service (800) 244-6224 www.mycigna.com
	Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	Cigna	Customer Service: (877) 478-7557 www.mycigna.com
	Flexible Spending Accounts	BenefitsWorkshop	Customer Service: (888) 537-3539 www.benefitsworkshop.com/margate
	Employee Assistance Program	Cigna	Customer Service: (877) 622-4327 www.mycigna.com
	Basic Life and AD&D Insurance	Cigna	Customer Service: (800) 362-4462 www.cigna.com
	Voluntary Life and AD&D Insurance	Cigna	Customer Service: (800) 362-4462 www.cigna.com
	Long Term Disability Insurance	Cigna	Customer Service: (800) 362-4462 www.cigna.com

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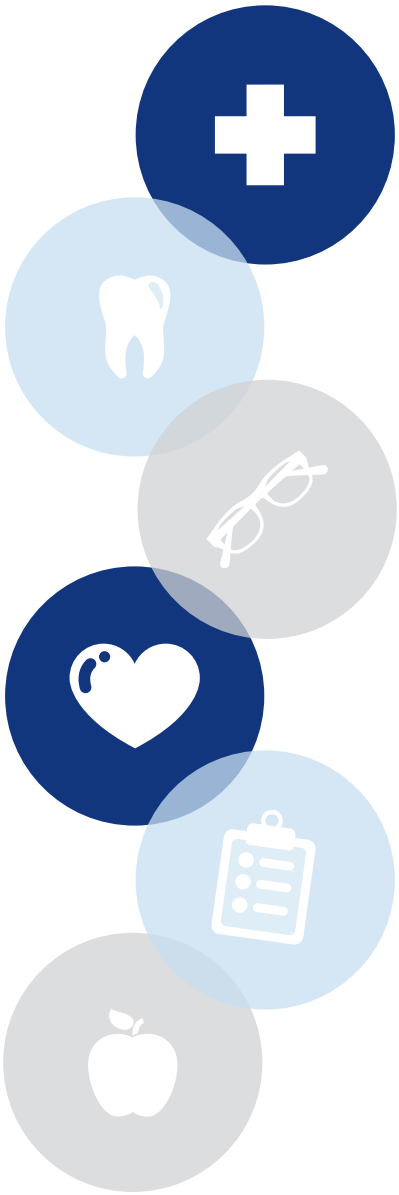

This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Margate reserves the right to amend, modify or terminate the plan at any time. This booklet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

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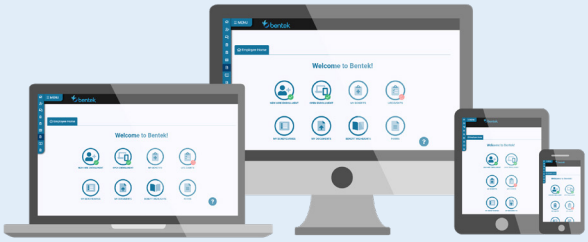
Introduction

The City of Margate provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the City's Personnel Policies, appropriate collective bargaining agreements, and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources.

Online Benefit Enrollment

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

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



To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/cityofmargate**
- ✓ 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 contact (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 Employee Benefits Center online, log on to:
www.mybentek.com/cityofmargate

Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*

Group Insurance Eligibility

The City's group insurance plan year is January 1 through December 31.

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 the month following 30 days of employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 1.

Separation of Employment

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

Dependent Eligibility

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

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

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent may continue to be covered on the medical plan to the end of the 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 & Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

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

Disabled Dependents

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

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

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

Taxable Dependents

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

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

Domestic Partner Coverage

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

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

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

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

Examples of Qualifying Events:

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

IMPORTANT NOTES

If employee experiences a Qualifying Event, **Human Resources must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. 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. 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. Cancellations will be processed at the end of the month. In the event of death, coverage terminates the day following the death. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Medical Insurance

The City offers medical insurance through Cigna to benefit-eligible employees. The costs per pay period for coverage are listed in the premium 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 Cigna's customer service.

Medical Insurance – Cigna LocalPlus IN (HMO Low) Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	City Cost	Total Premium
Employee Only	$69.50	$277.98	$347.48
Employee + Family	$189.16	$756.61	$945.77

Medical Insurance – Cigna LocalPlus IN (HMO High) Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	City Cost	Total Premium
Employee Only	$82.91	$331.62	$414.53
Employee + Family	$225.50	$901.99	$1,127.49

Medical Insurance – Cigna Open Access Plus Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost	City Cost	Total Premium
Employee Only	$84.97	$339.90	$424.87
Employee + Family	$231.48	$925.90	$1,157.38

Cigna | Customer Service: (800) 244-6224 | www.cigna.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 the employee's benefit options. A free paper copy of the SBC document may be requested or is available as follows:

From:	City of Margate Human Resources
Address:	5790 Margate Blvd. Margate, FL 33063
Phone:	(954) 935-5270
Website URL:	www.mybentek.com/cityofmargate

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

If there are any questions about the plan offerings or coverage options, please contact Human Resources.

Telehealth

Cigna MDLIVE provides access to telehealth services as part of the medical plan. Cigna 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 Cigna MDLIVE.

Cigna MDLIVE
MDLIVE Customer Service: (888) 726-3171 | www.MDLIVEforCigna.com
Cigna Customer Service (800) 244-6224 | www.mycigna.com

Other Available Plan Resources

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

Vision Discount Plan

The City provides a vision discount plan through Cigna when enrolled in one (1) of the group's medical plans. A brief summary of benefits is highlighted below. For more detailed information about the vision discount plan, please refer to the carrier's summary plan document or contact Cigna's customer service.

In-Network Only Benefits

The vision discount plan provides employee and covered dependent(s) coverage for routine eye care, including eye exams, and discounted rates for eyeglasses (lenses and frames). To schedule an appointment, employee and covered dependent(s) may select any network provider who participates in the Cigna Vision network only. At the time of service, routine vision examinations and basic optical needs will be discounted as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment. There is no coverage for services received out-of-network.

Vision Discount Plan At-A-Glance

Network	Cigna Vision
Services	**In-Network**
Eye Exam	$15 Copay
Frequency of Services	
Examination	24 Months
Lenses	
Single	20% Discount
Bifocal	
Trifocal	
Frames	
Allowance	20% Discount

Cigna LocalPlus IN (HMO Low) Plan At-A-Glance

Network	LocalPlus
Calendar Year Deductible (CYD)*	**In-Network**
Single	$1,000
Family	$2,000
Coinsurance	
Member Responsibility	20%
Calendar Year Out-of-Pocket Limit	
Single	$5,000
Family	$10,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit *(No PCP Election Required)*	$15 Copay
Specialist Office Visit *(No Referral Required)*	$25 Copay
Telehealth Services	$15 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)***	Covered at 100%
X-rays	Covered at 100%
Advanced Imaging *(MRI, PET, CT)*	$50 Copay + 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)*	20% After CYD
Outpatient Office Visit	$15 Copay
Prescription Drugs *(Rx)*	
Generic Preventive	Covered at 100%
Generic	$5 Copay
Preferred Brand Name	$30 Copay
Non-Preferred Brand Name	$90 Copay
Mail Order Drug *(90-Day Supply)*	2.5x Copay
Retail *(90-Day Supply)*	2.5x Copay

Locate a Provider

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

Plan References

Copays do not apply towards the calendar year deductible.

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

Important Notes

- *Services received by providers or facilities **not** in the LocalPlus network, will not be covered.*
- *Prior authorizations may be required before certain services can be received. If prior authorization is required and not obtained prior to receiving the services, the claim could be denied and all charges will be the employee's responsibility.*

Cigna LocalPlus IN (HMO High) Plan At-A-Glance

Locate a Provider

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

Plan References

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

Important Notes

- *Services received by providers or facilities **not** in the Cigna LocalPlus network, will not be covered.*
- *Prior authorizations may be required before certain services can be received. If prior authorization is required and not obtained prior to receiving the services, the claim could be denied and all charges will be the employee's responsibility.*

Network	LocalPlus
Calendar Year Deductible (CYD)	**In-Network**
Single	No Deductible
Family	No Deductible
Coinsurance	
Member Responsibility	0%
Calendar Year Out-of-Pocket Limit	
Single	$2,000
Family	$4,000
What Applies to the Out-of-Pocket Limit?	Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit *(No PCP Election Required)*	$15 Copay
Specialist Office Visit *(No Referral Required)*	$25 Copay
Telehealth Services	$15 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)**	Covered at 100%
X-rays	Covered at 100%
Advanced Imaging *(MRI, PET, CT)*	$50 Copay
Outpatient Surgery in Surgical Center	$50 Copay
Physician Services at Surgical Center	Covered at 100%
Urgent Care *(Per Visit)*	$25 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	$250 Copay
Outpatient Hospital *(Per Visit)*	$50 Copay
Physician Services at Hospital	Covered at 100%
Emergency Room *(Per Visit; Waived if Admitted)*	$150 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	$250 Copay
Outpatient Services *(Per Visit)*	Covered at 100%
Outpatient Office Visit	$15 Copay
Prescription Drugs *(Rx)*	
Generic Preventive	Covered at 100%
Generic	$5 Copay
Preferred Brand Name	$30 Copay
Non-Preferred Brand Name	$90 Copay
Mail Order Drug *(90-Day Supply)*	2.5x Copay
Retail *(90-Day Supply)*	2.5x Copay

Cigna Open Access Plus Plan At-A-Glance

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$300	$500
Family	$600	$1,000
Coinsurance		
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Limit		
Single	$1,500	$2,000
Family	$3,000	$4,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	10% After CYD	30% After CYD
Specialist Office Visit	10% After CYD	30% After CYD
Telehealth Services	10% After CYD	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	10% After CYD	30% After CYD
X-rays	10% After CYD	30% After CYD
Advanced Imaging *(MRI, PET, CT)*	10% After CYD	30% After CYD
Outpatient Surgery in Surgical Center	10% After CYD	30% After CYD
Physician Services at Surgical Center	10% After CYD	30% After CYD
Urgent Care *(Per Visit)*	10% After CYD	10% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After CYD	30% After CYD
Outpatient Hospital *(Per Visit)*	10% After CYD	30% After CYD
Physician Services at Hospital	10% After CYD	30% After CYD
Emergency Room *(Per Visit)*	10% After CYD	10% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After CYD	30% After CYD
Outpatient Services *(Per Visit)*	10% After CYD	30% After CYD
Outpatient Office Visit	10% After CYD	30% After CYD
Prescription Drugs *(Rx)*		
Generic Preventive	Covered at 100%	30% Coinsurance
Generic	$5 Copay	30% Coinsurance
Preferred Brand Name	$30 Copay	30% Coinsurance
Non-Preferred Brand Name	$90 Copay	30% Coinsurance
Mail Order Drug *(90-Day Supply)*	2.5x Copay	30% Coinsurance
Retail *(90-Day Supply)*	2.5x Copay	30% Coinsurance

Locate a Provider

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

Plan References

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

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

Important Notes

Prior authorizations may be required before certain services can be received. If prior authorization is required and not obtained prior to receiving the services, the claim could be denied and all charges will be the employee's responsibility.

Dental Insurance

Cigna Dental Care DHMO Plan

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

Dental Insurance – Cigna Dental Care DHMO Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$6.76
Employee + 1 Dependent	$13.38
Employee + Family	$23.79

In-Network Benefits

The Dental Care DHMO plan is an in-network only plan that requires all services be received by a Primary Dental Provider (PDP). Employee and dependent(s) may select any participating dentist in the Cigna Dental Care Access network to receive covered services. There is no coverage for services received out-of-network.

The Dental Care DHMO plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following page. Please refer to the summary plan document for a detailed listing of charges and benefits.

Out-of-Network Benefits

The Dental Care DHMO 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 two (2) routine cleanings per calendar year covered under the preventive benefit. Members can also receive two (2) additional cleanings at the charge of a copay.*
- *Referrals and prior authorizations are required to see specialists (Oral Surgeon, Periodontist, Orthodontist, etc.) within the network.*
- *Waiting periods and age limitations may apply.*
- *Children under age thirteen (13) may visit a pediatric dentist. Contact Cigna for a list of pediatric dentists in the network.*

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

Cigna Dental Care DHMO Plan At-A-Glance

Network	Cigna Dental Care Access	
Calendar Year Deductible (CYD)	**In-Network Only**	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Calendar Year Benefit Maximum	**In-Network Only**	
Per Member	Does Not Apply	
Class I Services: Diagnostic & Preventive Care	**Code**	**In-Network**
Office Visit*	N/A	$5 Copay
Observation Office Visit	9430	$6 Copay
Routine Oral Exam	0120/0150	$0 Copay
Routine Cleanings *(2 Per Calendar Year)*	1110/1120	$0 Copay
Bitewing X-rays *(2 Films Per Calendar Year)*	0272	$0 Copay
Complete X-rays *(1 Set Every 3 Calendar Years)*	0210	$0 Copay
Fluoride Treatments *(2 Per Calendar Year)*	1208	$0 Copay
Sealants *(Per Tooth)*	1351	$11 Copay
Emergency Care to Relieve Pain *(Minor Procedure)*	9110	$6 Copay
Class II Services: Basic Restorative Care		
Fillings *(Amalgam)*	2140/2150/2160	$0 Copay
Fillings *(Composite, Anterior)*	2330/2331/2332	$0 Copay
Fillings *(Composite, Posterior)*	2391	$65 Copay
Simple Extractions *(Erupted Tooth or Exposed Root)*	7140	$6 Copay
Surgical Removal of Tooth *(Impacted)*	7240	$100 Copay
Root Canal Therapy *(Molar; Excluding Final Restoration)*	3330	$275 Copay
General Anesthesia *(Each 15 Minute Increment)*	9223	$80 Copay
Class III Services: Major Restorative Care		
Bridges *(Porcelain Fused to Metal)*	6750	$210 Copay
Crowns *(Porcelain Fused to Metal)***	6240	$210 Copay
Dentures	5110/5120	$185 Copay + Lab
Class IV Services: Orthodontia		
Benefit — Dependent Child(ren) *(Up to Age 19)*	8670	$1,464 Copay
Benefit — Adult	8670	$2,160 Copay
Retention	8680	$285 Copay

Locate a Provider

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

Plan References

**Each patient is responsible for a $5 office visit fee, per office visit. The $5 fee is in addition to an other applicable patient charges.*

***Porcelain/ceramic substrate crowns on molar teeth are not covered.*

Important Notes

The summary has been provided as a convenient reference. For a full listing of covered services, exclusions and stipulations please refer to the carrier's summary plan document or contact Cigna's customer service.

Dental Insurance

Cigna Dental PPO Plan

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

Dental Insurance – Cigna Dental PPO Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$21.76
Employee + Family	$73.32

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 Total Cigna DPPO network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

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

Out-of-Network Benefits

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

Calendar Year Deductible

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

Calendar Year Benefit Maximum

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

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

Cigna Dental PPO Plan At-A-Glance

Network	Total Cigna DPPO	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,500	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(4 Per Calendar Year)*		
Bitewing X-rays *(2 Per Calendar Year)*		
Complete X-rays *(1 Per 36 Months)*		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% After Deductible	Plan Pays: 80% After Deductible *(Subject to Balance Billing)*
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Periodontal Services		
General Anesthesia		
Class III Services: Major Restorative Care		
Oral Surgery	Plan Pays: 50% After Deductible	Plan Pays: 50% After Deductible *(Subject to Balance Billing)*
Crowns		
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Dependent Children Up To Age 19)*	Plan Pays: 50%	Plan Pays: 50% *(Subject to Balance Billing)*

Locate a Provider

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

Plan References

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

Important Notes

- *Each covered family member may receive up to four (4) routine cleanings per calendar year covered under the preventive benefit.*
- *Late entrant provisions, waiting periods, frequency and/or age limitations may apply for certain services.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-determination of Benefits" upon the request of the dental provider. This will assist employees with determining their 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

Cigna Vision Buy-Up Plan

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

Vision Insurance – Cigna Vision Buy-Up Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$2.54
Employee + Family	$8.62

In-Network Benefits

The Vision Buy-Up plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employee and covered dependent(s) may select any network provider who participates in the Cigna Vision network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

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

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.

Claims Mailing Address
Cigna Vision Claims Department
PO Box 385018 | Birmingham, AL 35238-5018

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

Cigna Vision Buy-Up Plan At-A-Glance

Network	Cigna Vision	
Services	**In-Network**	**Out-of-Network**
Eye Exam	$10 Copay	Up to $45 Reimbursement
Materials	$10 Copay	Reimbursement is Based on Type of Service
Frequency of Services		
Examination	12 Months	
Lenses	12 Months	
Frames	12 Months	
Contact Lenses	12 Months	
Lenses		
Single	Covered at 100% After $10 Materials Copay	Up to $32 Reimbursement
Bifocal		Up to $55 Reimbursement
Trifocal		Up to $65 Reimbursement
Frames		
Allowance	Up to $150 Retail Allowance	Up to $83 Reimbursement
Contact Lenses*		
Non-Elective *(Medically Necessary)*	Covered 100%	Up to $210 Reimbursement
Elective *(Fitting, Follow-up & Lenses)*	Up to $150 Retail Allowance	Up to $120 Reimbursement

Locate a Provider

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

Plan References

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

Important Notes

- *Benefits are valid once per calendar year and cannot be used in conjunction with other discounts, promotions or prior orders. A member who elects to use other discounts and/or promotions in lieu of his/her vision benefits may file a claim to receive reimbursement according to the out-of-network reimbursement amounts.*
- *Member options, such as 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 BenefitsWorkshop. The FSA plan year is from January 1 to December 31.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employee to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year. There are two (2) types of FSAs:

Health Care FSA

This account allows participant to set aside up to an annual maximum of $2,750. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note, if family income is over $20,000, this reimbursement option will likely save participants more money than 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

- The Health Care FSA allows a grace period at the end of the plan year (75 days). The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends. Once the grace period ends, any unused funds still remaining in the account will be forfeited.
- The Health Care FSA has a run out period at the end of the plan year (120 days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year and/or grace period.
- When a plan year ends and all claims have been filed, all unused funds will be forfeited and not returned.
- Employee can enroll in an FSA only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility period.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted 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. BenefitsWorkshop may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the City. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $38.46 based on a 26 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

	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 22.65% = 15% + 7.65% FICA	- $6,568	- $6,795
After Tax Expenses	- $0	- $1,000
Spendable Income	$22,432	$22,205
Tax Savings	**$227**	

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.* ***This rule is known as "use-it or lose-it."***

BenefitsWorkshop
Customer Service: (888) 537-3539 | www.benefitsworkshop.com/margate

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

To Access Services

Employee and family member(s) must register and create a user ID on www.mycigna.com to access EAP services.

Cigna | Customer Service: (877) 622-4327 | www.mycigna.com
Employer ID: margate

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides Basic Term Life insurance for all benefit eligible employees at no cost, through Cigna. Eligible employees will receive a benefit amount of $35,000.

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.

Basic Dependent Life Insurance

Basic Dependent Life Insurance coverage is optional at the cost of $2.00 per month, and provides spouse and child(ren) coverage (Six (6) months to age 19) in the amount of $5,000 (coverage for children under the age of six (6) months old may be covered for a reduced benefit of $500).

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

Cigna | Customer Service: (800) 362-4462 | www.cigna.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 Cigna. 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 $100,000.**

- Units can be purchased in increments of $10,000, up to 5 times annual salary, to the maximum of $300,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 40% of the benefit amount at age 70
  - Reduces to 25% of the benefit amount at age 75
- Rates are subject to increase annually and are based on the employee's age band.
- Coverage will end upon retirement or separation of employment from the City.

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 $150,000, not to exceed 50% of the employee's Voluntary Employee Life coverage amount.
- Benefit amounts are subject to the following age reduction schedule based on the employees age:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 40% of the benefit amount at age 70
  - Reduces to 25% of the benefit amount at age 75

Voluntary Life and AD&D Insurance Rate Table

Monthly Premium

Age Bracket *(Based on Employee Age)*	Employee/Spouse* *(Rate Per $1,000 of Benefit)*
< 30	$0.160
30-34	$0.185
35-39	$0.225
40-44	$0.275
45-49	$0.365
50-54	$0.595
55-59	$1.055
60-64	$1.475
65-69	$2.585
70 +	$4.055
Child(ren)	$0.310

**Spouse coverage terminates when the 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.
- Employee may elect coverage in increments of $1,000, up to a maximum of $10,000 for eligible unmarried children age six (6) months to age 19 (or to age 26 if a full-time student).
- Child(ren) under the age of six (6) months may be covered for a reduced benefit of $250.

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

Cigna | Customer Service: (800) 362-4462 | www.cigna.com

Long Term Disability

Long Term Disability (LTD) insurance may be provided to employees according to their collective bargaining agreement, through Cigna. The LTD benefit pays employees a percentage of their gross monthly earnings if they become disabled due to a non-work related injury or illness.

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 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income.

Please contact Human Resources for additional eligibility and benefit information.

Cigna | Customer Service: (800) 362-4462 | www.cigna.com

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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CITY OF
MARGATE
Together We Make It Great

GEHRING GROUP
EMPLOYEE BENEFITS | RISK MANAGEMENT

4200 Northcorp Parkway, Suite 185
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970
www.gehringgroup.com

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