

2020



2021

EMPLOYEE  
BENEFIT HIGHLIGHTS



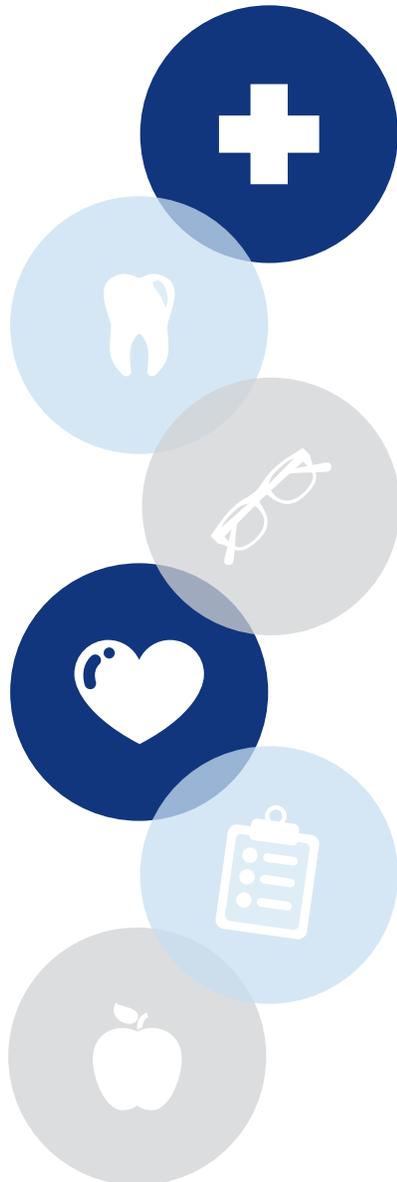
## Contact Information

<b>Human Resources</b>	Renee Govig Director Human Resources	Phone: (561) 841-3358
	Melinda Wong Human Resources Specialist	Phone: (561) 841-3314
	Cynthia Mederos Human Resources Admin. Asst.	Phone: (561) 882-1155
 <b>Online Benefit Enrollment</b>	Bentek	(888) 5-Bentek (523-6835) www.mybentek.com/npb Email: support@mybentek.com
 <b>Medical Insurance</b>	Cigna	Customer Service: (800) 244-6224 www.myCigna.com
 <b>Health Savings Account</b>	HSA Bank	Customer Service: (800) 357-6246 www.hsabank.com
 <b>Telehealth</b>	AmWell	Customer Service: (855) 667-9722 www.AmWellforCigna.com
	MDLIVE	Customer Service: (888) 726-3171 www.MDLIVEforCigna.com
 <b>Dental Insurance</b>	Cigna	Customer Service: (800) 244-6224 www.myCigna.com
 <b>Vision Insurance</b>	EyeMed	Customer Service: (866) 939-3633 www.eyemed.com
 <b>Flexible Spending Account</b>	BenefitsWorkshop	Customer Service: (888) 537-3539 www.benefitsworkshop.com
 <b>Basic Life and AD&amp;D Insurance</b>	Cigna	Customer Service: (800) 732-1603 www.myCigna.com
	<b>Voluntary Life and AD&amp;D Insurance</b>	Cigna
 <b>Long Term Disability Insurance</b>	Cigna	Customer Service: (800) 362-4462 www.myCigna.com
 <b>Employee Assistance Program</b>	American Behavioral	Customer Service: (800) 925-5327 www.americanbehavioral.com
 <b>Supplemental Insurance</b>	Colonial Life	Agent: Alejandro Villasuso Phone: (305) 978-3355 Customer Service: (800) 325-4368 www.coloniallife.com



## Table of Contents

Introduction.....	1
Online Benefit Enrollment.....	1
Group Insurance Eligibility.....	2
Qualifying Events and Section 125.....	3
Medical Insurance.....	4
Other Available Plan Resources.....	4
Telehealth.....	4
Cigna Open Access Plus HDHP Plan At-A-Glance.....	5
Cigna Open Access Plus In-Network Only Plan At-A-Glance.....	6
Health Savings Account.....	7-8
Dental Insurance.....	9
Cigna Dental DHMO Plan At-A-Glance.....	10
Dental Insurance.....	11
Cigna Dental PPO Plan At-A-Glance.....	12
Vision Insurance.....	13
EyeMed Vision Select Plan At-A-Glance.....	14
Flexible Spending Accounts.....	15-16
Basic Life and AD&D Insurance.....	17
Voluntary Life Insurance.....	17-18
Long Term Disability.....	18
COBRA Benefits.....	19
Employee Assistance Program.....	19
Supplemental Insurance.....	20
Notes.....	20



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



## Introduction

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

## Online Benefit Enrollment

The Village 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/npb](http://www.mybentek.com/npb)
- ✓ 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](mailto: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/npb](http://www.mybentek.com/npb)**

*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 Village group insurance plan year is October 1 through September 30.

### Employee Eligibility

Employees are eligible to participate in the Village's insurance plans if they are full-time employees or part-time employees working a minimum of 30 hours per week or in excess of 1560 hours within the established measurement period. Coverage will be effective the first of the month following 30 days of employment. For example, if employee is hired on June 15, then the effective date of coverage will be August 1.

### Separation of Employment

If employee separates employment from the Village, 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 and/or dependent child(ren) of the participant or spouse. The term "child" includes any of the following:

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

### Dependent Age Requirements

**Medical Coverage:** A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

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

**Vision Coverage:** A dependent child may be covered through end of calendar year in which child turns age 26 or to age 30 if primarily dependent upon the employee for support, living in their home or as a full-time or part-time student.

### Disabled Dependents

Coverage for an unmarried 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 dependent child(ren) under employee's medical, dental and vision insurance plans may continue to have the related coverage premium(s) payroll deducted on a pre-tax basis through the end of the calendar year in which the dependent child reaches age 26. Beginning January 1 of the calendar year in which the 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 each 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, and vision insurance as well as contributions to Flexible Spending Accounts (FSA) accounts 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 an 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 process 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 on the day following the death. Employees will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

### 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 benefit options. A free paper copy of the SBC document may be requested by contacting:

**From:** Human Resources  
**Address:** 501 U.S. Highway 1  
North Palm Beach, FL 33408  
**Phone:** (561) 882-1155  
**Email:** hr@village-npb.org  
**Website URL:** www.mybentek.com/npb

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 or at the following web address: [www.mybentek.com/npb](http://www.mybentek.com/npb).

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



## Medical Insurance

The Village 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 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 Premiums Cigna Open Access Plus HDHP Plan 24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$0.00
Employee + One Dependent	\$107.35
Employee + Family	\$140.86

### Medical Insurance Premiums Cigna Open Access Plus In-Network Only Plan 24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$49.30
Employee + One Dependent	\$117.34
Employee + Family	\$153.83

Cigna | Customer Service: (800) 244-6224

## 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.myCigna.com](http://www.myCigna.com).

## Telehealth

Cigna provides access to two (2) telehealth services as part of the medical plan. AmWell and MDLIVE are convenient phone and video consultation companies that provide immediate medical assistance for many conditions.

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

- ✓ Sore Throat
- ✓ Headache
- ✓ Stomachache
- ✓ Fever
- ✓ Cold And Flu
- ✓ Allergies
- ✓ Rash
- ✓ Acne
- ✓ UTIs And More

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

### Cigna

**AmWell** | Customer Service: (855) 667-9722 | [www.AmWellforCigna.com](http://www.AmWellforCigna.com)

**MDLIVE** | Customer Service: (888) 726-3171 | [www.MDLIVEforCigna.com](http://www.MDLIVEforCigna.com)



## Cigna Open Access Plus HDHP Plan At-A-Glance



### Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit [www.myCigna.com](http://www.myCigna.com). When completing the necessary search criteria, select **Open Access Plus** network.



### Plan References

**\*Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage.

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

Network	Open Access Plus (OAP)	
<b>Plan Year Deductible (PYD)</b>	<b>In-Network</b>	<b>Out-of-Network*</b>
Single	\$1,500	\$3,000
Family	\$3,000	\$6,000
<b>Coinsurance</b>		
Member Responsibility	10%	40%
<b>Plan Year Out-of-Pocket Limit</b>		
Single	\$3,000	\$6,000
Family	\$6,000	\$12,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
<b>Physician Services</b>		
Primary Care Physician (PCP) Office Visit	10% After PYD	40% After PYD
Specialist Office Visit	10% After PYD	40% After PYD
Telehealth Services	10% After PYD	Not Covered
<b>Non-Hospital Services; Freestanding Facility</b>		
Clinical Lab (Bloodwork)**	10% After PYD	40% After PYD
X-rays	10% After PYD	40% After PYD
Advanced Imaging at Independent Facility (MRI, PET, CT)	10% After PYD	40% After PYD
Outpatient Surgery in Surgical Center	10% After PYD	40% After PYD
Physician Services at Surgical Center	10% After PYD	40% After PYD
Urgent Care Facility (Per Visit)	10% After PYD	40% After PYD
<b>Hospital Services</b>		
Inpatient Hospital (Per Admission)	10% After PYD	40% After PYD
Outpatient Surgery at Hospital (Per Visit)	10% After PYD	40% After PYD
Physician Services at Hospital	10% After PYD	40% After PYD
Emergency Room (Per Visit; Waived if Admitted)	10% After PYD	10% After In-Network PYD
<b>Mental Health / Alcohol &amp; Substance Abuse</b>		
Inpatient Hospital Services (Per Admission)	10% After PYD	40% After PYD
Outpatient Services (Per Visit)	10% After PYD	40% After PYD
Outpatient Office Visit	10% After PYD	40% After PYD
<b>Prescription Drugs (Rx)</b>		
Generic	\$10 After PYD	50% After PYD
Preferred Brand Name	\$50 After PYD	50% After PYD
Non-Preferred Brand Name	\$80 After PYD	50% After PYD
Mail Order Drug (90-Day Supply)	3x Retail Copay After PYD	50% After PYD



## Cigna Open Access Plus In-Network Only Plan At-A-Glance

Network	Open Access Plus (OAP)
<b>Plan Year Deductible (PYD)</b>	
Single	\$1,000
Family	\$3,000
<b>Coinsurance</b>	
Member Responsibility	10%
<b>Plan Year Out-of-Pocket Limit</b>	
Single	\$4,000
Family	\$8,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx
<b>Physician Services</b>	
Primary Care Physician (PCP) Office Visit	\$25 Copay
Specialist Office Visit	\$45 Copay
Telehealth Services	\$25 Copay
<b>Non-Hospital Services; Freestanding Facility</b>	
Clinical Lab (Bloodwork)*	No Charge
X-rays	No Charge
Advanced Imaging at Independent Facility (MRI, PET, CT)	\$250 Copay
Outpatient Surgery in Surgical Center	10% After PYD
Physician Services at Surgical Center	10% After PYD
Urgent Care Facility (Per Visit)	\$50 Copay
<b>Hospital Services</b>	
Inpatient Hospital (Per Admission)	10% After PYD
Outpatient Surgery at Hospital (Per Visit)	10% After PYD
Physician Services at Hospital	10% After PYD
Emergency Room (Per Visit; Waived if Admitted)	\$250 Copay
<b>Mental Health / Alcohol &amp; Substance Abuse</b>	
Inpatient Hospital Services (Per Admission)	10% After PYD
Outpatient Services (Per Visit)	No Charge
Outpatient Office Visit	\$45 Copay
<b>Prescription Drugs (Rx)</b>	
Generic	\$10 Copay
Preferred Brand Name	\$30 Copay
Non-Preferred Brand Name	\$50 Copay
Mail Order Drug (90-Day Supply)	3x Retail Copay



### Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit [www.myCigna.com](http://www.myCigna.com). When completing the necessary search criteria, select **Open Access Plus** network.



### Important Notes

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



### Plan References

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



## Health Savings Account

The Cigna High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollees to open a Health Savings Account (HSA). An HSA is an interest-bearing account where funds may be used to help pay employee and dependent(s) deductible, coinsurance and any qualified health care expenses not covered by the plan.

### 2020-2021 Plan Year Funding:

- **Employee Only: \$1,500**
- **Employee + Family: \$3,000**

Employee may opt to fund an HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free).

- 2020 IRS Contribution Limitations: \$3,550 (individual coverage); \$7,100 (family coverage)
- 2021 IRS Contribution Limitations: \$3,600 (individual coverage); \$7,200 (family coverage)

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

Guidelines regarding the HSA are established by the IRS.

### What To Know About An HSA

- Employee owns the HSA funds from day one and decides how and when to spend the money.
- No use-it or lose-it rules; funds are in the account when needed, now or in the future. Participant cannot fund a traditional Health Care FSA; however, participant may fund a Limited Purpose FSA for dental and vision expenses only.
- HSA funds may earn interest.
- The HSA will be funded with employer contributions. If employee desires to fund the remaining IRS HSA Combined Contribution Limit balance may do so with pre-tax payroll deductions.
- HSA dollars can be used tax-free for all eligible health care expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employees plan for retirement.
- An account holder can write a check or withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.
- Account holders can access HSA statements at any time and track account balance and activity online at [www.hsabank.com](http://www.hsabank.com).

- To be eligible to open an HSA, employee must be covered by a high deductible health plan. Employee may not be covered under another medical plan that is not a high deductible health plan including a plan employee's spouse may have where he/she has family coverage. Please Note: Eligibility status to qualify for an HSA is specifically driven by employee and NOT dependents.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Over-age dependent is not able to use HSA funds for qualified expenses, even if dependent is covered under the medical plan as Federal Law does not recognize them as a qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits the Village from contributing HSA funds into the account. If employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts.
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare will receive the full family HSA funding and can contribute into the HSA up to the maximum contribution amounts. These funds can be utilized for active employee and spouse expenses.
- Active employee ON Medicare and with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse will not receive any HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

*\*Please contact Human Resources for further information regarding funding variations towards employer HSA contributions.*



## Health Savings Account: Understanding HSAs (Continued)

Question	HSAs Health Savings Accounts
<p><b>What is an HSA?</b></p>	<p>Employee who enrolls in the Cigna Open Access Plus (OAP) HDHP Plan will receive a Health Savings Account (HSA) funded by the Village and employee may also additionally fund the account with tax-free dollars. HSA funds can be used for qualified IRS 213 expenses. Visit <a href="http://www.irs.gov">http://www.irs.gov</a> for a listing of 213 expenses.</p>
<p><b>How much is funded into the account?</b></p>	<p><b>2020-2021 Plan Funding:</b></p> <ul style="list-style-type: none"> <li>• Employee Only: \$1,500</li> <li>• Employee + Family: \$3,000</li> </ul> <p>Employee may opt to fund an HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free).</p> <ul style="list-style-type: none"> <li>• 2020 IRS Contribution Limitations: \$3,550 (individual coverage); \$7,100 (family coverage)</li> <li>• 2021 IRS Contribution Limitations: \$3,600 (individual coverage); \$7,200 (family coverage)</li> </ul> <p>Individuals ages 55 and older can also make additional "catch-up" contributions up to \$1,000 annually.</p> <p><b>Please Note:</b> Funding amount will be pro-rated for New Hires and for Qualifying Events making eligible tier level or plan changes.</p>
<p><b>How are the funds accessed?</b></p>	<p>HSA funds can be accessed by:</p> <ol style="list-style-type: none"> <li>1) Health Savings Account Visa card, or</li> <li>2) Check book.</li> </ol>
<p><b>What happens to unused funds at the end of the 2020-2021 Plan Year?</b></p>	<p>The year-end balance remains in the HSA Account and continues to earn interest.</p>
<p><b>What happens to unused funds if employee discontinues participation in an HSA Plan, separates employment, or retires from the Village?</b></p>	<p>Employee owns the HSA funds from day one and decides how and when to spend them. HSA funds are portable from one employer to another.</p>
<p><b>What are some examples of qualified expenses that would be eligible for reimbursement?</b></p>	<p>HSA funds can be used to meet the plan year deductible. Most covered services count toward the deductible, including prescriptions costs, physician visits, dental visits, hospital visits, laboratory work, etc. All expenses must be medically necessary.</p>
<p><b>Can an employee have an HSA AND a Flexible Spending Account (FSA)?</b></p>	<p>Yes, employees may have a Limited Purpose FSA in addition to an HSA, but the member's ability to utilize an FSA for certain expenses is limited to dental and vision expenses. For more information on FSAs, please refer to the Flexible Spending Accounts pages 15 and 16.</p>



## Dental Insurance

### Cigna Dental DHMO Plan

The Village 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 plans, please refer to the carrier's summary plan document or contact Cigna's customer service.

#### Dental Insurance Premiums – Cigna DHMO Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$0.00
Employee + Family	\$2.64

#### In-Network Benefits

The DHMO plan is an in-network only plan that requires all services be rendered 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 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 plan's summary of coverage document for a detailed listing of charges and what is covered.

#### Out-of-Network Benefits

The 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 two (2) routine cleanings per calendar year covered under the preventive benefit. Additional cleanings are available at the charge of a copay.
- Waiting periods and age limitations may apply for some services.
- Children under age 13 may visit a pediatric dentist. Contact Cigna for a list of pediatric dentists in the network.
- Out-of-area dental emergencies may be considered for coverage, if deemed as a true emergency.

Cigna | Customer Service: (800) 244-6224 | [www.myCigna.com](http://www.myCigna.com)



## Cigna Dental DHMO Plan At-A-Glance

Network		Cigna Dental Care Access	
<b>Calendar Year Deductible (CYD)</b>		<b>In-Network Only</b>	
Per Member		Does Not Apply	
Per Family			
Calendar Year Maximum			
<b>Class I Services: Diagnostic &amp; Preventive Care</b>	<b>Code</b>	<b>In-Network</b>	
Office Visit	9430	\$6	
Routine Oral Exam (2 Per Calendar Year)	0150	\$0	
Routine Cleanings (2 Per Calendar Year)	1110/20	\$0	
Bitewing X-rays (2 Per Calendar Year)	0274	\$0	
Complete X-rays (1 Every 3 Years)	0210	\$0	
Fluoride Treatments (2 Per Calendar Year)	1208	\$0	
Sealants (Per Tooth)	1351	\$11	
Emergency Care to Relieve Pain (During Regular Hours)	9110	\$6	
<b>Class II Services: Basic Restorative Care</b>			
Fillings (Amalgam)	2140	\$0	
Fillings (Composite — 2 Surfaces, Anterior/Posterior)	2331/2392	\$0/\$75	
Simple Extractions (Non Surgical)	7111	\$6	
Root Canal Therapy (Molar)	3330	\$275	
Deep Cleaning (1 Per Lifetime)	4355	\$45	
Periodontal Scaling (1 to 3 Teeth Per Quadrant; Limit 4 Quadrants Per Year)	4342	\$35	
Periodontal Scaling (4 or More Teeth; Limit 4 Quadrants Per Year)	4341	\$45	
Periodontal Maintenance (4 Per Year)	4910	\$35	
General Anesthesia (First 15 Minutes; Per Visit)	9223	\$80	
<b>Class III Services: Major Restorative Care*</b>			
Crowns (Porcelain Fused to Metal)	6240	\$210	
Bridges	6241	\$195	
Dentures (Upper/Lower)	5110/20	\$185	
<b>Class IV Services: Orthodontia - 24 Month Treatment Fee*</b>			
Benefit — Child (Up to Age 19)	8670	\$1,464	
Benefit — Adult	8670	\$2,160	



### Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit [www.myCigna.com](http://www.myCigna.com). When completing the necessary search criteria, select **Cigna Dental Care Access (formerly Cigna Dental Care HMO)** network.



### Plan References

\*Additional charges may apply for some services. Please see the plan summary or contact Cigna's customer service for details specific to a procedure.



## Dental Insurance

### Cigna Dental DPPO Plan

The Village 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 plans, please refer to the carrier's summary plan document or contact Cigna's customer service.

#### Dental Insurance Premiums – Cigna Dental DPPO Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	\$10.03
Employee + Family	\$33.30

#### In-Network Benefits

The Cigna DPPO plan provides benefits for services received from in-network and out-of-network providers. **It is 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 is the Total Cigna DPPO network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Plan Year Deductible (PYD) and then coinsurance based on the plan's charge limitations.

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

#### Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Total 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 rendered by an out-of-network dentist, the member will pay the out-of-network benefit plus the difference between the amount that Cigna reimburses MRC for such services and the amount charged by the dentist. This is known as balance billing. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

#### Plan Year Deductible

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

#### Plan Year Benefit Maximum

The maximum benefit (coinsurance) the Cigna DPPO plan will pay for each covered member is \$1,500 for in-network or out-of-network services combined, excluding orthodontia services.



#### IMPORTANT NOTES

- Each covered family member may receive up to two (2) routine cleanings per plan year.
- Waiting periods and age limitations may apply.

Cigna | Customer Service: (800) 244-6224 | [www.myCigna.com](http://www.myCigna.com)



## Cigna Dental PPO Plan At-A-Glance

Network	Total Cigna DPP0	
Plan Year Deductible (PYD)	In-Network	Out-of-Network*
Per Member		\$50
Per Family		\$150
Waived for Class I Services?		Yes
<b>Plan Year Benefit Maximum</b>		
Per Member (Includes Class I Services)		\$1,500
<b>Class I Services: Diagnostic &amp; Preventive Care</b>		
Routine Oral Exam (2 Per Plan Year)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)
Routine Cleanings (2 Per Plan Year)		
Complete X-rays (1 Set Every 3 Years)		
Bitewing X-rays (2 Per Plan Year)		
<b>Class II Services: Basic Restorative Care</b>		
Fillings (Amalgam and Composite)	Plan Pays: 80% After PYD	Plan Pays: 80% After PYD (Subject to Balance Billing)
Simple Extractions		
Endodontics (Root Canal)		
Periodontal Services		
Oral Surgery		
General Anesthesia		
<b>Class III Services: Major Restorative Care</b>		
Crowns	Plan Pays: 50% After PYD	Plan Pays: 50% After PYD (Subject to Balance Billing)
Bridges		
Dentures		
<b>Class IV Services: Orthodontia</b>		
Lifetime Maximum		\$1,000
Benefit (Dependent Children Up To Age 19)		50%



### Locate a Provider

To search for a participating provider, contact Cigna customer service or visit [www.myCigna.com](http://www.myCigna.com). When completing the necessary search criteria, select **Total Cigna DPP0** network.



### Plan References

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



### Important Notes

- Each covered family member may receive up to two (2) routine cleanings per calendar year covered under the preventive benefit.
- For any dental work expected to cost \$200 or more, the plan will provide a "Pre-Determination of Benefits" document 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

### EyeMed Vision Select Plan

The Village offers vision insurance through EyeMed to benefit-eligible employees. The costs per month 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 EyeMed's customer service.

#### Vision Insurance Premiums – EyeMed Select Plan

12 Monthly Deductions

Note: The deduction is not every pay period.

Tier of Coverage	Employee Cost
Employee Only	\$6.67
Employee + 1 Dependent	\$12.69
Employee + 2 or more Dependents	\$18.62

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

#### Plan Year Deductible

There is no plan year deductible.

#### Plan Year Out-of-Pocket Maximum

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

#### EyeMed

Customer Service: (866) 939-3633 | [www.eyemed.com](http://www.eyemed.com)



## EyeMed Vision Select Plan At-A-Glance

Network		Select	
Services		In-Network	Out-of-Network
Eye Exam and/or Materials		\$10 Copay	Up to \$35 Reimbursement
<b>Frequency of Services</b>			
Examination			12 Months
Lenses			12 Months
Frames			24 Months
Contact Lenses			12 Months
<b>Lenses</b>			
Single		\$10 Copay	Up to \$25 Reimbursement
Bifocal		\$10 Copay	Up to \$40 Reimbursement
Trifocal		\$10 Copay	Up to \$60 Reimbursement
<b>Frames</b>			
Basic, Preferred or Non-Preferred		Up to \$120 Allowance Then 20% Off Balance Over \$120	Up to \$48 Reimbursement
<b>Contact Lenses*</b>			
Non-Elective ( <i>Medically Necessary</i> )		No Charge	Up to \$200 Reimbursement
Elective ( <i>Fitting, Follow-up &amp; Lenses</i> )	Conventional	Up to \$135 Allowance Plus 15% Off Balance Over \$135	Up to \$95 Reimbursement
	Disposable	Up to \$135 Allowance Plus Balance Over \$135	Up to \$95 Reimbursement



### Locate a Provider

To search for a participating provider, contact EyeMed's customer service or visit [www.eyemed.com](http://www.eyemed.com). When completing the necessary search criteria, choose **Select** 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 Account

The Village offers Flexible Spending Accounts (FSA) administered through BenefitsWorkshop. The FSA plan year runs 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.

The Village offers three (3) plans: Health Care FSA, Limited Purpose FSA, and Dependent Care FSA.

- **Health Care FSA:** Available to eligible employees who are **not** enrolled in the Cigna Open Access Plus HDHP Plan with an HSA. The Health Care FSA covers medical, dental, and vision expenses that are not paid by insurance.
- **Limited Purpose FSA:** Available to eligible employees who are enrolled in the Cigna Open Access Plus HDHP Plan with an HSA. **A Limited Purpose Health Care FSA may be used for qualified dental and vision expenses.**
- **Dependent Care FSA:** Covers day care expenses for qualified dependents when it is necessary for employee and legal spouse, if married to work.

### Health Care FSA

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

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

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

### Dependent Care FSA

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

Please note, if family income is over \$20,000, this reimbursement option will likely save participants more money than dependent day care tax credit taken on a tax return. To qualify, dependents must be:

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

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

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

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees\*
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses\*
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery\*
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees\*
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

*\*These items are eligible expenses under the Limited Purpose FSA.*

**Log on to <http://www.irs.gov/publications/p502/index.html> for additional details regarding qualified and non-qualified expenses.**



## Flexible Spending Account *(Continued)*

### FSA Guidelines

- The Health Care FSA has a run out period at the end of the plan year (until December 31) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year (October 1- September 30).
- **Any unused funds, after a plan year ends and all claims have been filed, cannot be returned or carried forward to the next plan year.**
- When a plan year ends and all claims have been filed, all unused funds will be forfeited and will not be returned.
- Employee can enroll in an FSA only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility period.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services they have not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as Federal law does not recognize them as a qualified dependent.

### Filing a Claim

#### Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA 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 by a number of medical providers/facilities and at most pharmacy retail outlets. BenefitsWorkshop may request supporting documentations for expenses paid with a debit card. Failure to provide supporting documentation when requested may result in suspension of the card and account until funds are substantiated or refunded back to the Village. This card will not expire at the end of the benefit year. 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!



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
<b>Tax Savings</b>	<b>\$227</b>	

**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."**

#### Claims Mailing Address

PO Box 56828, Jacksonville, FL 32241

#### BenefitsWorkshop

Customer Service: (888) 537-3539 | Fax: (904) 880-2830

[www.benefitsworkshop.com/npb](http://www.benefitsworkshop.com/npb)



## Basic Life and AD&D Insurance

### Basic Term Life Insurance

The Village provides Basic Term Life insurance for all eligible employees, at no cost, through Cigna. Eligible employees receive a benefit amount of \$50,000.

### Accidental Death & Dismemberment Insurance

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

***Always remember to keep your beneficiary forms updated. Beneficiary forms may be updated at anytime through Bentek.***

Cigna | Customer Service: (800) 732-1603 | [www.myCigna.com](http://www.myCigna.com)

## Voluntary Life 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 coverages. Voluntary Life insurance offers coverage for employee, spouse 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 to a maximum of \$500,000.
- Coverage is reduced by 50% of the original amount at age 70.
- Voluntary AD&D coverage matches the Voluntary Life amount elected.

### 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 in order for spouse to participate.
- Units can be purchased in increments of \$5,000, to a maximum of \$150,000, not to exceed 50% of the employee's Voluntary Life coverage amount.
- Spouse Life insurance coverage will terminate at age 70.
- Voluntary AD&D coverage matches the Voluntary Life amount elected.



## Voluntary Life Insurance *(Continued)*

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

- Employee must participate in the Voluntary Employee Life plan in order for dependent child(ren) to participate.
- For eligible unmarried children, from six (6) months through age 21, or up to age 25 if a full-time student, employee can elect a \$10,000 benefit amount not to exceed 50% of the employee's Voluntary Life coverage amount.
- Children 15 days to six (6) months may be covered for a \$500 benefit amount.
- Coverage is \$0.50 per month for \$10,000 for any eligible dependent child(ren) enrolled, regardless of how many.

### To calculate your cost, complete this chart:

Employee \_\_\_ units × \$ \_\_. \_\_ per unit = \$ \_\_. \_\_  
 Spouse \_\_\_ units × \$ \_\_. \_\_ per unit = \$ \_\_. \_\_  
 Children \$10,000 @ \$.50 = = \$ \_\_. \_\_  
 Total Monthly Cost \$ \_\_. \_\_

**Voluntary Life/AD&D Insurance Monthly Rate Table**  
 Rate Per \$1,000 of Benefit

Age Bracket <i>(Based On Age)</i>	Employee	Spouse
0-19	\$0.114	\$0.108
20-24	\$0.114	\$0.108
25-29	\$0.114	\$0.108
30-34	\$0.115	\$0.108
35-39	\$0.148	\$0.134
40-44	\$0.211	\$0.176
45-49	\$0.312	\$0.252
50-54	\$0.470	\$0.369
55-59	\$0.796	\$0.593
60-64	\$0.882	\$0.88
65-69	\$1.477	\$1.474
70-74	\$2.603	\$2.597
75+	\$9.784	\$9.763

Cigna | Customer Service: (800) 732-1603 | [www.myCigna.com](http://www.myCigna.com)

## Long Term Disability

The Village provides Long Term Disability (LTD) insurance at no cost to all eligible employees through Cigna. The LTD benefit pays a percentage of gross monthly earnings if employee becomes disabled due to an illness or non-work related injury. A summary of the plan's benefits is provided below.

### Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings to a benefit maximum of \$6,000 per month.
- Employee must be disabled for 90 days prior to becoming eligible for the benefits (known as the elimination period).
- Benefit will begin on the 91st day of the disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- Employee will continue to receive benefits for 24 months if employee is unable to return to their own occupation.
- After 24 months, if employee can return to any occupation in which employee is suitably trained, educated, and capable of performing, employee must return to that occupation (if the salary of that occupation does not meet the salary of employee's own occupation, the plan will pay the difference).
- The duration of the LTD benefit is based on employee's age at the time the disabling event occurs.
- Benefits may be reduced by other income benefits.

Cigna | Customer Service: (800) 362-4462 | [www.myCigna.com](http://www.myCigna.com)



## COBRA Benefits

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that most employers sponsoring group health insurance plans offer employees and families the opportunity for a temporary extension of group insurance coverage, at group rates, in certain instances where coverage under the plan would otherwise end. Employee, spouse of employee, or a dependent child of employee covered by the Village's medical, dental, vision and/or FSA plan(s) has/have the right to choose this continuation of coverage if coverage is lost due to a COBRA Qualifying Event. Employee must immediately notify Human Resources when a covered member experiences a Qualifying Event (employee has up to 30 days to provide notification).

### COBRA Qualifying Events for Employee are:

- Reduction in hours of employment (that disqualifies group insurance participation eligibility); or
- Termination of employment (for reasons other than gross misconduct).

### COBRA Qualifying Events for Spouse of Employee are:

- The death of a spouse; or
- A termination of a spouse's employment (for reasons other than gross misconduct) or a reduction in a spouse's hours of employment; or
- Termination of employment with the Village; or
- Divorce or legal separation from a spouse; or
- A spouse becomes entitled to Medicare.

### COBRA Qualifying Events for Dependent Child of Employee are:

- The death of a parent; or
- A termination of the parent's employment (for reasons other than gross misconduct) or a reduction in the parent's hours; or
- Termination of employment with the Village; or
- Parent's divorce or legal separation; or
- A parent becomes entitled to Medicare; or
- Dependent child ceases to be a dependent child according to the plan's eligibility definition.

## Employee Assistance Program

The Village cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through American Behavioral. EAP offers employee as well as 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's or family member's well-being. Coverage includes six (6) face-to-face visits with a specialist, per person, per issue per year, telephonic consultations, online material/tools and webinars. EAP offers counseling services on issues such as:

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

### Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor/manager), Human Resources will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor/manager will not receive specific information regarding the referred employee's case but will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

### American Behavioral

Customer Service: (800) 925-5327 | [www.americanbehavioral.com](http://www.americanbehavioral.com)



# DRAFT 2



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

© 2016, Gehring Group, Inc., All Rights Reserved

Last Modified: July 30, 2020 10:15 AM