CLEARWATER

BRIGHT AND BEAUTIFUL · BAY TO BEACH

2022 EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

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	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) Email: support@myBentek.com www.mybentek.com/clearwater
	Employee Health Center	Evernorth Direct Health	Phone: (727) 298-1788 https://mychart.my-wellnesscenter.com/MyChart/
	Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Telehealth	MDLIVE	Customer Service: (888) 726-3171 www.MDLIVEforCigna.com
	Dental Insurance	Sun Life	Customer Service: (800) 442-7742 www.sunlifedentalbenefits.com
		Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	Humana	Customer Service: (877) 398-2980 www.humana.com
	Employee Assistance Program	Cigna Behavioral Health	Customer Service: (877) 622-4327 www.mycigna.com
	Life Insurance	Human Resources	Phone: (727) 562-4870
	Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 Agent: Frank D'Ascoli | Phone: (727) 514-7977 Email: frank.dascoli@verizon.net
	Flexible Spending Accounts	HealthEquity/Aflac	HealthEquity Customer Service: (866) 242-3458 www.healthequity.com/wageworks Aflac Agent: Frank D'Ascoli | Phone: (727) 514-7977 Email: frank.dascoli@verizon.net
	Claim, Billing & Benefit Assistance	Gehring Group	Phone: (800) 244-3696 Email: cityofclearwater@gehringgroup.com

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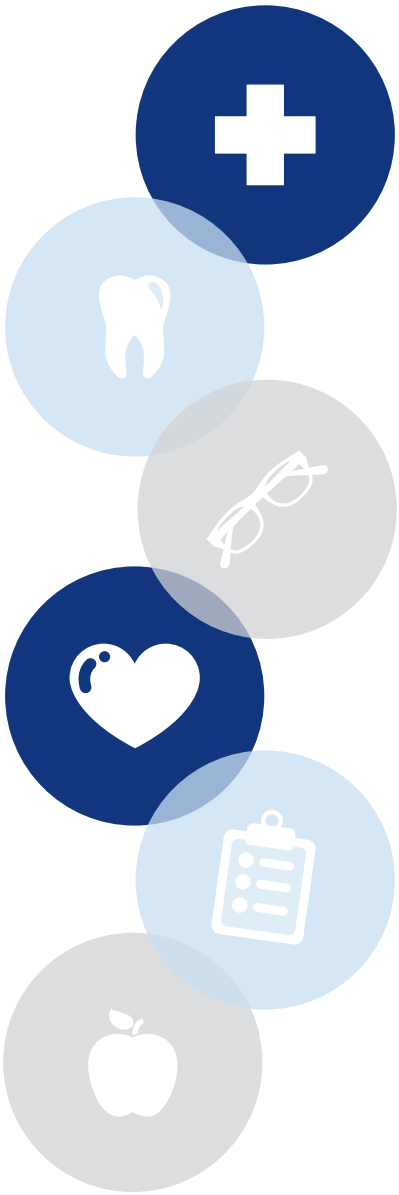

This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Clearwater reserves the right to amend, modify or terminate the plan at any time. This booklet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

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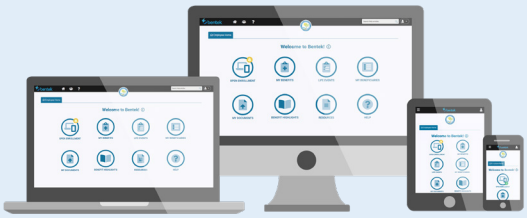
Introduction

The City of Clearwater's Employee Benefit Highlights booklet provides summaries of the City's group insurance offerings for all benefit-eligible employees. This information is provided to new hires and during the City's annual Open Enrollment. It is important that employees make knowledgeable decisions when it comes to electing benefits. Please refer to each plan's Summary Plan Description to learn about any enrollment conditions or coverage stipulations. If employees have any questions regarding the contents of this booklet, please contact Human Resources at (727) 562-4870.

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/cityofclearwater**

  Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com, Monday through Friday during regular business hours 8:30am - 5:00pm.

To access Bentek using a mobile device, scan code.

Group Insurance Eligibility

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

Employee Eligibility

Eligible employees working a minimum of 37.5 hours per week will be eligible to participate in all City insurance plans.

Eligible employees working an average of 30 to 37.5 hours per week will be eligible to participate in the City's medical, dental, vision, FSA and Aflac insurance plans only, excluding Life insurance and retirement benefit offerings.

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

Separation of Employment

If employee separates employment from the City, insurance will continue through the end of the month in which the separation occurred (except for Life insurance, Health Care FSA and Dependent Care FSA which terminates coverage on the date in which separation occurs). 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 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.

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

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

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

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.

Group Insurance Eligibility *(Continued)*

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 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 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 employee's tax return.

Domestic Partner

A Domestic Partner and any eligible dependent(s) will be provided the same benefits afforded to all employees and eligible dependents excluding American Family Life Assurance Company of Columbus (Aflac), Family Medical Leave Act (FMLA), and Flexible Spending Accounts (FSA). A Domestic Partner is defined as a person of the same or opposite sex with whom employee or retiree has established a domestic partnership in accordance with the Policy, rules, and procedures determined by the City and will be required to complete an Affidavit of Domestic Partnership. IRS guidelines state that employee may not receive a tax advantage on any portion of premium paid related to domestic partner coverage. Employee insuring Domestic Partner and/or child dependent(s) of a Domestic Partner will see the insurance premium deductions on a post-tax basis and any amount subsidized by the employer will be reported as "imputed income" to the employee.

A Domestic Partnership will be required to meet all of the following eligibility requirements:

1. Both individuals are at least eighteen (18) years old and mentally competent to consent to a contract.
2. Both are each other's sole domestic partner and intend to remain so indefinitely.
3. Both have common residence and, at the time of submitting an affidavit, have resided together on a continuous basis for the preceding six (6) months intending to continue the arrangement.
4. Both are not married under Florida law nor are domestic partners with anyone else and have not been so during the preceding six (6) months.
5. Both are not related by blood in any way that would prohibit legal marriage in the State of Florida.
6. Both share responsibility for a significant measure of each other's common welfare and financial obligations.

Contact Human Resources for further details and rates if covering a Domestic Partner at any time during the upcoming plan year.

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

The City operates under strict IRS Guidelines, therefore employee who experiences a Qualifying Event, **must contact Human Resources within 30 days of the Qualifying Event**. Beyond 30 days, requests will be denied and the employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of the employee or dependent who continues to be enrolled but no longer meets eligibility requirements. The change is effective either the date employee notified Human Resources or the first of the following month. In the event of death, coverage will terminate the date following the death. Employee 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 employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	City of Clearwater
	Human Resources
Address:	100 South Myrtle Avenue, Clearwater, FL 33756
Phone:	(727) 562-4870
At Website URL:	www.myclearwater.com
At Bentek URL:	www.mybentek.com/clearwater

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/or obtained by contacting Human Resources or at the following web address: www.mybentek.com/clearwater.

If there are any questions about the plan offerings or coverage options, please contact Human Resources at (727) 562-4870.

Employee Health Center

City of Clearwater Employee Health Center

The Employee Health Center is available to employees, retirees, and eligible dependents enrolled in the City's medical insurance plan. The EHC provides the care employees and dependents need for **all** non-emergency illnesses. Schedule an appointment with the medical staff to learn more about the Employee Health Center or refer to the Summary of Benefits and Coverage (SBC).

The EHC is administered by Evernorth Direct Health, a third-party vendor. Utilization is entirely voluntary. **All visits with Employee Health Center staff are completely confidential and no personal information is shared with the employer**.

Why choose the Employee Health Center?

- Full range of primary care services available for no charge
- Dedicated appointment times
- No charge for prescriptions dispensed at the EHC (a list of available Rx's can be found on the Launchpad)
- 100% confidential and HIPAA compliant
- Extra programs for no charge:
  - Skin Screenings
  - Biometrics
  - Flu Shots
  - Shingles Vaccine
  - Covid-19 Vaccine

To schedule an appointment at the Employee Health Center, contact Evernorth Direct Health by calling (727) 298-1788.

Hours of operation are 7:00 a.m. to 5:00 p.m., Monday through Friday. Appointments are required; however, walk-ins may be accommodated based on availability and/or the severity of the issue.

Please Note: *Employees will be allowed up to one (1) hour during the work day, with no charge to employee's sick leave, to attend a scheduled appointment at the Employee Health Center.*

Employee Health Center
Powell Professional Center
401 Corbett Street, Suite 400
Clearwater, FL 33756
Phone: (727) 298-1788
Email: clearwateremployeehealthcenter@evernorth.com

To schedule an appointment please visit:
https://mychart.my-wellnesscenter.com/MyChart/

The Health Center will be closed New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving & day after, and Christmas Day.

MotivateMe

The City and Cigna care about the health of employees and retirees and want to help them get healthy and stay healthy. This incentive plan was created to encourage employees and retirees to participate in annual wellness screenings, preventative care visits, online health assessments, annual physicals and health coaching. The program is available to all employees and retirees that are covered under the City's 2022 medical insurance plan. MotivateMe is administered through Cigna and employees and retirees may earn up to $200 in rewards. Register online at myCigna.com or through the myCigna app and click on the "Wellness" tab and look for "Incentive Awards." Please contact the Human Resources Department with any questions regarding the incentive program or for more information.

Please Note: Employees who are covered as the dependent spouse of another employee should contact Human Resources to access their reward.

MotivateMe Incentives

Item	Criteria	Frequency	Reward	Notes
Wellness Screening	Performed at clinic – immediate results reviewed with patient by clinic staff	1/Year	$50	Gatekeeper – this must be completed to be eligible for all other events
Online Health Assessment	Complete Online Assessment			
Complete Annual Physical	Available through medical plan or clinic	1/Year	$50	
Preventative Screenings	Colon Cancer Cervical Cancer Breast Cancer Prostate Cancer Skin Screening	2/Year	$75/Screening	
Chronic Coaching	Telephonic or Online	Up to 2/Year	$25/Coaching	
			$200 Annual Maximum	

Should you separate from employment, if you have not redeemed your incentive within 90 days, the incentive rewards are will not be available for redemption.

Omada

Employees who have been diagnosed with pre-diabetes and qualify may participate in Omada. Omada is a personalized lifestyle program designed to help employees make gradual changes in eating, exercise, sleep and managing stress. Employees who complete 16 sessions of this program may qualify for a $100 incentive reward. This is separate from the MotivateMe program incentives. For more information, please contact the Human Resources Department.

Medical Insurance

The City offers medical insurance through Cigna to benefit-eligible employees. The costs per pay period for employee & retiree coverage are listed in the premium tables below. For more detailed information about the medical plan, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Cigna's customer service.

Medical Insurance – Cigna Open Access Plus (OAP) Plan

Employee Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + One Dependent	$165.87
Employee + Family	$348.38
Dual Coverage	$0.00

Medical Insurance – Cigna Open Access Plus (OAP) Plan

Retiree/COBRA* Monthly Premium Rates

Tier of Coverage	Retiree Cost	COBRA Cost*
Retiree/COBRA Member	$774.45	$789.93
Retiree/COBRA Member + One Dependent	$1,326.99	$1,353.53
Retiree/COBRA Member + Family	$2,177.41	$2,220.96

**A 2% administrative charge has been added to the monthly rate for COBRA.*

How the Deductible and Co-Insurance Works

- For services requiring a co-payment, members pay only the co-payment amount each time services are received.
- For services requiring co-insurance, members pay the full cost of services up to the deductible amount, and pay a percentage (co-insurance) of the remaining cost of services up to the plan's out-of-pocket limit.
- Once employee reaches the out-of-pocket limit, the plan pays the full cost of any covered services (including prescriptions).
- Only services requiring co-insurance go toward satisfying the deductible. All services, including deductible, co-insurance and co payments towards office visits and prescription drugs, will go toward satisfying the out-of-pocket limit.
- **There is no cross accumulation between in-network and out-of-network deductible or out-of-pocket maximum. The amount employee pays for in-network covered expenses only counts toward employee's in-network deductible and in-network out-of-pocket maximum. The amount employee pays for out-of-network covered expenses only count toward employee's out-of-network deductible and out-of-pocket maximum.**

Other Available Plan Resources

Cigna offers all enrolled members 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.

Healthy Rewards

Cigna's Healthy Rewards is provided to members automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to www.mycigna.com and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- ✓ Vision Care
- ✓ LASIK Vision Correction services
- ✓ Fitness Club Discounts
- ✓ Nutrition Discounts
- ✓ Hearing Care
- ✓ Tobacco Cessation
- ✓ Alternative Medicine

Cigna | Customer Service: (800) 244-6224 | www.mycigna.com
24-Hour Health Information Line: (800) 564-9286

Telehealth

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

This benefit is provided to all enrolled members. Registration is suggested and should be completed prior to receiving 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-emergent 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
MDLIVE | Customer Service: (888) 726-3171 | www.MDLIVEforCigna.com

Cigna Open Access Plus (OAP) Plan At-A-Glance

Network	Open Access Plus (OAP)	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$2,000	$2,000
Family	$4,000	$4,000
Coinsurance		
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Maximum		
Single	$3,500	$3,500
Family	$7,000	$7,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$20 Copay	30% After CYD
Specialist Office Visit	$40 Copay	30% After CYD
Telehealth Services	No Charge	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	No Charge	30% After CYD
X-rays/Advanced Imaging *(MRI, PET, CT) (i.e. Akumin)*	No Charge	30% After CYD
Outpatient Surgery in Surgical Center *(Per Visit)*	10% After CYD	$300 Copay + 30% After CYD
Outpatient Physician Services	10% After CYD	30% After CYD
Urgent Care Center *(Per Visit; Waived if Admitted)*	$75 Copay	$75 Copay
Hospital Services		
Hospital Pre-Admission Requirement	Yes, or you pay 100%	Yes, or you pay 100%
Inpatient *(Per Admission)*	10% After CYD	$500 PAD + 30% After CYD
Physician Services at Hospital	10% After CYD	30% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$150 Copay	$150 Copay
Ambulance *(Emergency Services Only)*	10% After CYD	10% After CYD
Outpatient Rehabilitation		
Facility Charge *(60 Visits Annual Maximum)*	$40 Per Visit	30% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient *(Prior Authorization is Required)*	No Charge	30% Coinsurance
Outpatient Facility *(Prior Authorization is Required)*	$10 Copay Per Visit	30% Coinsurance
Prescription Drugs *(Retail 30-Day Supply)*		
Generic	$10 Copay	30% Coinsurance
Preferred Brand Name	$30 Copay	30% Coinsurance
Non-Preferred Brand Name	$50 Copay	30% Coinsurance
Mail-Order Drug *(90-Day Supply)*	2x Retail Copay	Not Covered

Locate a Provider

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

Plan References

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

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

Important Notes

- *Please remember that out-of-network providers may balance bill for charges that exceed the allowed billed amount, even once the out-of-pocket limit has been reached.*
- ***Specialty medications can be filled the first time through the pharmacy, but subsequent fills need to be done through the mail order pharmacy.***

Dental Insurance

Sun Life and Cigna Plans

The City offers a variety of dental insurance options to eligible employees through Sun Life and Cigna Employee Benefits. Dental insurance is 100% employee paid and semi-monthly premiums are payroll deducted 24 times a year. The employee costs are shown on the premium table below. A brief description of the dental plan options and a summary of the benefits are shown below and on the following page. For detailed coverages, exclusions, and stipulations, please refer to the carrier's benefit summary or contact the carrier's customer service number.

The Prepaid Dental DHMO Plans: Sun Life Low Option, Cigna P5X00, Cigna F1-09

If a member enrolls in a prepaid dental plan, they must choose a dentist from a list of participating providers and make copays for member's general dental needs. If a specialist is required, member must select a specialist from a list of participating specialists. The member can either pay the appropriate copays from the provider's Schedule of Benefits and Subscriber copays or pay at discounted prices. Covered member must be treated by in-network dentists or specialists. Prepaid dental plan highlights include the following:

- NO deductibles or claim forms
- NO pre-existing condition limitation
- NO maximum benefit level
- NO benefit waiting period for any service

Pediatric Dental benefits are available for children up to age 17 through the Cigna DHMO plan. Child(ren) age 17 or older must be seen by a general dentist.

The PPO/Traditional (Indemnity) Dental Insurance Plan: Cigna DPPO

Cigna provides a PPO/Traditional (indemnity) dental plan that gives the member freedom of choice when selecting dental care providers. The member pays the cost of dental care at the time services are received and files a claim form. After satisfying a deductible, the member will be responsible for the applicable coinsurance level depending on the type of dental service performed. Highlights of the PPO/Traditional (Indemnity) Plan include the following:

- Freedom to visit a dentist of choice at any time
- Claims must be filed
- Reduced out-of-pocket expenses when visiting participating PPO dentist
- Annual Deductible - $50 per participant for basic, major, and orthodontic services - maximum of three (3) deductibles assessed per family - $150
- Annual benefit maximum - $1,100 per person
- Orthodontics - $1,000 lifetime maximum
- No benefit waiting period for preventive, basic and major services.
- A missing tooth limitation does apply for the first 12 months of continuing coverage.

Dental Insurance – Active Employees 2022 Semi-Monthly Pay Period Premium Deductions

Tier of Coverage	Sun Life Low Option	Cigna P5X00	Cigna F1-09	Cigna DPPO
Employee Only	$3.25	$8.18	$10.23	$18.84
Employee + One Dependent	$5.50	$15.21	$19.04	$38.18
Employee + Family	$8.67	$19.80	$24.79	$56.28

Dental Insurance – Retirees 2022 Monthly Premium Rates

Tier of Coverage	Sun Life Low Option	Cigna P5X00	Cigna F1-09	Cigna DPPO
Retiree Only	$6.50	$16.35	$20.45	$37.68
Retiree + One Dependent	$10.99	$30.42	$38.08	$76.35
Retiree + Family	$17.34	$39.59	$49.57	$112.56

Sun Life | Customer Service: (800) 442-7742
www.sunlifedentalbenefits.com
Sun Life Dental Directory: https://www.slfserviceresources.com.
Choose Find A Dentist, DHMO or Prepaid Dental Plan, Florida, Heritage Series.

Cigna | Customer Service: (800) 244-6224 | www.mycigna.com
Cigna Dental Directory: https://hcpdirectory.cigna.com/web/public/providers.
For Cigna P5X00 or Cigna F1-09, choose HMO plans.
For Cigna DPPO, choose PPO plans.

Sun Life and Cigna Dental Plans At-A-Glance

Prepaid Dental DHMO Summary of Benefits		Sun Life Low Option Plan*	Cigna P5X00*	Cigna F1-09*	Aflac
Codes	**Sample Procedures**	**Copay / Fee Schedule**			**Aflac Pays**
	Examinations				
9430	Consultation/Office Visit	$10	$5	$0	$35
0120	Periodic Oral Exam & Diagnosis	$0	$0	$0	$35
	X-Rays				
0272	Bitewings 2 Films	$0	$0	$0	$20
0210	Complete Series	$0	$0	$0	$20
	Preventative Care				
1110	Complete Prophylaxis (Adult)	$0	$0	$0	$35
1510	Space Maintainer	$60 + Lab	$25 + Lab	$0	$115
	Restorative				
2330	Resin-One Surface, Anterior	$35	$0	$0	$70
2391	Resin-One Surface, Posterior (Adult)	$60	$55	$47	$60
	Endodontics				
3310	Anterior Tooth (Excludes Final Restoration)	$135	$80	$12	$210
3330	Molar Tooth	$245	$250	$280	$350
	Periodontics				
4210	Gingivectomy/Gingivoplasty (Per Quadrant)	$120	$130	$220	$180
4260	Osseous Surgery (Per Quadrant)	$350	$295	$465	$350
	Prosthodontics				
5110	Complete Upper Denture	$295 + Lab	$150***	$500	$485
5120	Complete Lower Denture	$375 + Lab	$150***	$500	$485
	Fixed Crown & Bridge				
6240	Bridge Pontic-Porcelain Fused to High Noble Metal/Unit	$265 + Lab	$185***	$380	$350
6750	Crown-Porcelain Fused to High Noble Metal/Unit	$265 + Lab	$185***	$390	$350
	Oral Surgery				
7111	Extraction Single Tooth	$20	$5	$12	$55
7220	Extraction-Soft Tissue Impaction	$65	$50	$21	$120
7240	Extraction-Full Bony Impaction	$100	$90	$120	$180
	Orthodontics**				
Child	Orthodontics 8660/70/80, 8080, 8999	25% discount	$2,414	$3,307	
Adult	Orthodontics 8660/70/80, 8090, 8999	25% discount	$3,014	$4,027	

PPO / Traditional Summary of Benefits	Cigna DPPO	
Benefit Schedule	**In Network**	**Out of Network****
Annual Deductible		
Per Person	$50	$50
Family Maximum	$150	$150
Waived for Preventative?	Yes	Yes
Benefit Level		
Preventative	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontics - Child (24 Months)	50%	50%
Maximum Benefit		
Annual Benefit Maximum	$1,100	$1,100
Orthodontia Annual Maximum	$500	$500
Orthodontia Lifetime Maximum	$1,000	$1,000
Out-of-Network Benefits		
Payable Level	N/A	70th Percentile
Major Services	12 months	
Benefit Classification:		
Endodontics	Basic	Basic
Periodontics	Basic	Basic

**Member must select a participating dentist from the provider listing and notify the carrier of member's selection in order for benefits to be payable.*

***Out-of-network balance billing is the difference between the "allowed amount" an insurance company will pay to an in-network provider and the higher amount that an out-of-network provider charges members. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility and may be the responsibility of the employee.*

****Copays for these services do not include the additional cost of noble metal alloys, high noble metal alloys, titanium or titanium alloys. The additional cost of precious metal shall not exceed $150 per unit and $75 per unit for porcelain fused to metal (only molars) Porcelain/ceramic substrate crowns on molars are not covered.*

*****Codes represent a typical orthodontia treatment plan. Actual costs may vary for an individual's plan. Treatment extending over 24 months is not covered and will be charged at the provider's reasonable and customary rates.*

Vision Insurance

Humana Vision Care Plan

The City offers vision insurance through Humana to benefit-eligible employees. A brief description of the Humana Vision Care plan and summary of benefits is provided below. Vision insurance is 100% employee paid and semi-monthly premiums are deducted from employee's paycheck 24 times a year. The employee costs per pay period are shown on the premium table below. For detailed coverages, exclusions and stipulations, please refer to the Humana's benefit summary or contact Humana's customer service.

Vision Insurance – Humana Vision Care Plan

Employee Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	$2.56
Employee + One Dependent	$5.12
Employee + Family	$6.85

Vision Insurance – Humana Vision Care Plan

Retiree/COBRA* Monthly Premium Rates

Tier of Coverage	Retiree Cost
Retiree Only	$5.12
Retiree + One Dependent	$10.24
Retiree + Family	$13.69

**A 2% administrative charge will be added to the monthly rate for COBRA.*

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, covered members can select any optometrist or ophthalmologist that participates in the Humana Insight 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 optional upgrades are available at an additional discount. There is no calendar year deductible or out-of-pocket maximum, however, there are benefit reimbursement maximums for certain services.

How to Locate a Provider

To search for a participating provider:

1. Go to Humana.com and click "Find a Doctor"
2. Select Vision and click "Go"
3. Select the Humana Vision (Humana Insight Network)
4. A page will pop up where search criteria can be added

Services	In Network
Eye Exam	$10 copay (once every 12 months)
Lenses (single, bifocal, trifocal)	$15 copay (once every 12 months)
Frames	Up to $130 Allowance plus an additional 20% discount above $130 (once every 24 months)
Contact Lenses Non-elective (Medically Necessary)*	100% (once every 12 months)
Contact Lenses Elective (Fitting, Follow-up & Lenses)*	Up to $130 Allowance plus an additional 15% discount above $130 (once every 12 months)
Diabetic Eye Care (Includes Care and Testing)	No Charge

Contact Humana's customer service for an out-of-network reimbursement schedule.

**Contact lenses are in lieu of lenses/frames. Medically necessary contact lenses require prior authorization.*

Please Note: *Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount. Please refer to Humana's benefit summary or contact Humana's customer service for additional information.*

Humana | Customer Service: (877) 398-2980 | www.humana.com

Employee Assistance Program

The City provides at no cost to employees, a comprehensive Employee Assistance Program (EAP), which is available to employees and each household family member. The EAP offers unlimited telephonic counseling and up to five (5) face-to-face sessions, per person, per issue, with a licensed professional through a confidential program that is protected by State and Federal laws. The EAP program is available to help individuals gain a better understanding of problems that affect them, locate the best professional help for the particular problem, and decide upon a plan of action. All EAP counselors are professionally trained, certified, and licensed in their fields.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employees and each household family member free and convenient access to a range of confidential and professional services to help them address a variety of problems that can negatively affect well-being such as:

- ✓ Anxiety
- ✓ Stress
- ✓ Depression
- ✓ Life Improvement
- ✓ Family and/or Marriage Problems
- ✓ Grief and Bereavement
- ✓ Substance Abuse
- ✓ Gambling and Other Addictions
- ✓ Legal and Financial Concerns

Are Services Confidential?

Yes. Voluntary participation in EAP services is completely confidential. However, if participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), permission to communicate certain aspects of employee's care (attendance at sessions, adherence to treatment plans, etc.) to referring Human Resources may be requested or required. Human Resources will not receive specific information regarding referred employee's care, they will only receive reports on whether referred employee is complying with attendance and prescribed treatment plan.

To Access Services

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

Please Note: *Mental Health and Substance Abuse is a covered medical benefit under the City's group medical insurance plans with Cigna. However, there is still some assistance available through the City's EAP program that may be beneficial for acute situations, such as face-to-face or telephonic counseling sessions. For more information regarding the EAP offerings for these conditions, please contact customer service or log onto the myCigna.com site.*

Cigna Behavioral Health | Customer Service: (877) 622-4327
www.mycigna.com

Life Insurance

The City provides each benefit-eligible employee with Life insurance in the following amounts, at no cost to the employee:

- CWA – One and one-half times employee's annual base salary up to a maximum of a $50,000 benefit
- FOP and IAFF – $2,500 benefit
- SAMP – $2,500 benefit plus one times employee annual base salary
  - › SAMP employees also have the ability to purchase additional coverage in increments of $50,000 up to a maximum of five (5) times annual salary or $500,000. Newly hired or newly eligible SAMP employees can elect up to $150,000 coverage without submission of Evidence of Insurability for up to 31 days following initial date of eligibility. Any election of life insurance more than 31 days after the date of initial eligibility and/or the election of any amount exceeding $150,000 will require the submission of Evidence of Insurability and approval by the carrier.

SAMP employees can contact Human Resources for plan details and premium rates, changes can only be made during New Hire Enrollment and Open Enrollment.

Human Resources | Phone: (727) 562-4870

Voluntary Supplemental Insurance: Aflac Individual Plans

The City offers a variety of supplemental insurance plans through Aflac. Aflac plans may be purchased separately on a voluntary basis and premiums payroll deducted. Aflac pays money directly to the members, regardless of what other insurance plans they may have.

A description of each available plan and bi-weekly premium rates have been provided below. To learn more about these Aflac plans and/or schedule a personal appointment, contact the City's Aflac Agent, Frank D'Ascoli, at (727) 514-7977.

Aflac Accident Advantage Plan

Covers on-the-job and off-the-job injuries due to accidents for employee and covered family member(s).

Employee	$9.30	One Parent Family	$16.58
Employee & Spouse	$15.21	Two Parent Family	$23.40

Hospital Choice Plan

Aflac will pay a hospital confinement benefit of $2,000 when covered person is confined for 23 hours or more. $2,000 benefit will be paid if hospital confinement occurs 90 days from the previous confinement. No Lifetime Maximum. Benefits also include $25 physician visit reimbursements, diagnostic imaging, in-patient and out-patient surgery and daily hospital confinement. See policy brochure for details.

18-49	Base Plan	Base + EB Rider	Base + HSSC Rider	Base + HSSC Rider
Individual	$25.55	$31.40	$34.78	$40.63
One Parent Family	$31.46	$43.10	$44.20	$55.84
Employee & Spouse	$38.09	$50.38	$54.99	$67.28
Two Parent Family	$38.29	$53.18	$55.45	$70.34

50-59	Base Plan	Base + EB Rider	Base + HSSC Rider	Base + HSSC Rider
Individual	$25.81	$32.44	$37.64	$44.27
One Parent Family	$31.66	$43.56	$46.16	$58.06
Employee & Spouse	$40.17	$53.95	$63.64	$77.42
Two Parent Family	$40.50	$55.65	$64.75	$79.90

60-75	Base Plan	Base + EB Rider	Base + HSSC Rider	Base + HSSC Rider
Individual	$27.30	$34.00	$42.71	$49.41
One Parent Family	$31.92	$44.08	$50.97	$63.13
Employee & Spouse	$44.14	$58.05	$73.52	$87.43
Two Parent Family	$44.40	$60.20	$75.80	$91.60

- **Base Plan** pays **$2,000** upon 24 hr Confinement which covers the Cigna deductible. It also pays for ER, short stays and rehab services.
- **Extended Benefits (EB) Rider** pays Dr visits, imaging, lab tests, ambulance, etc.
- **Hospital Stay & Surgical Care (HSSC) Rider** pays initial assistance benefits, surgery, invasive diagnostic exams, daily confinement, and more.

Voluntary Supplemental Insurance: Aflac Individual Plans *(Continued)*

Cancer Protection Plan

Although medical insurance is usually adequate for most illnesses, it cannot always withstand the financial burden cancer can impose on employee and family.

Individual: $22.47	**One Parent Family:** $22.47	**Employee & Spouse:** $40.42	**Two Parent Family:** $40.42

Critical Care Protection Plan

Level I with $500 Annual Building Benefit Rider - Medical science and early, fast detection have increased survival rates for many serious medical conditions. Aflac provides the financial assistance to help employees get back on their feet if employee is faced with expensive treatment and loss of income for any of the specified health events listed.

Ages	Individual	One Parent Family	Employee + Spouse	Two Parent Family
18 - 35	$5.53	$6.11	$8.58	$9.62
36 - 45	$8.91	$9.30	$14.69	$15.99
46 - 55	$12.03	$12.42	$20.74	$22.17
56 - 70	$15.67	$16.06	$28.67	$30.42

Short Term Disability

Guaranteed Issue Benefits. Provides coverage for disabilities resulting from a covered sickness or off-the-job injury. 3-month Disability Benefit Period. 7-day Elimination Period. Benefits payable when policyholder's earnings are less than 80% of pre-disability salary.

Annual Income		$19,000	$24,000	$27,000	$32,000	$36,000	$39,000	$43,000	$47,000	$50,000	$55,000	$58,000
Monthly Benefit		**$1,000**	**$1,200**	**$1,400**	**$1,600**	**$1,800**	**$2,000**	**$2,200**	**$2,400**	**$2,600**	**$2,800**	**$3,000**
Age	**18-64**	$11.05	$13.26	$15.47	$17.68	$19.89	$22.10	$24.31	$26.52	$28.73	$30.94	$33.15
	65-74	$13.65	$16.38	$19.11	$21.84	$24.57	$27.30	$30.03	$32.76	$35.49	$38.22	$40.95

Annual Income		$63,000	$69,000	$72,000	$78,000	$88,000	$93,000	$102,000	$116,000	$120,000	$125,000
Monthly Benefit		**$3,200**	**$3,400**	**$3,600**	**$3,800**	**$4,000**	**$4,200**	**$4,400**	**$4,600**	**$4,800**	**$5,000**
Age	**18-64**	$35.36	$37.57	$39.78	$41.99	$44.20	$46.41	$48.62	$50.83	$53.04	$55.25
	65-74	$43.68	$46.41	$49.14	$51.87	$54.60	$57.33	$60.06	$62.79	$65.52	$68.25

Aflac Dental Plan

Aflac's dental plan supplements a member's current dental plan by providing cash benefits directly to members for dental services. There is no network however; waiting periods may apply depending on services needed. Policy annual maximum $1,680 per covered person for the first year. Increases of $120 per year for the first five years.

Individual: $11.64	**One Parent Family:** $20.35	**Employee & Spouse:** $20.48	**Two Parent Family:** $29.32

Aflac | Customer Service: (800) 992-3522 | Agent: Frank D'Ascoli | Phone: (727) 514-7977 | Email: Frank.DAscoli@verizon.net | Fax: (877) 442-3522

Flexible Spending Accounts

The City offers Flexible Spending Accounts (FSA) administered through HealthEquity/Aflac. 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 that 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 that are 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 they wish to have 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 $2,850. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). Examples of common expenses that qualify for reimbursement are listed below.

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

Dependent Care FSA

Qualified expenses include day care centers, preschool, and before/after school care for eligible children and adults. This account allows participants 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.

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

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

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

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

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

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

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Employee must re-elect the dollar amount they wish to contribute to FSAs in Bentek each year.
- Employee may carry over up to $570 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed. Dependent Care funds CANNOT be carried over.
- The Health Care FSA has a run out period at the end of the plan year (90 days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year (January 1 - December 31).
- When a plan year ends and all claims have been filed with the exception of the $570 rollover for the Health Care FSA, all unused funds will be forfeited and NOT returned. To check rollover balance, please call HealthEquity/Aflac at (866) 242-3458 .
- If employee separates employment from the City, their FSA card is immediately turned off. Outstanding claims must be submitted within 30 days via fax or online in order to be paid. Claims incurred after the date of termination will not be paid. In some circumstances an FSA may be continued through COBRA.
- Employee can enroll in either or both FSAs during 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 which are reimbursed through an FSA.
- Domestic Partners are not eligible as Federal law does not recognize them as a qualified dependents.
- **Irrevocable Election Rule: IRS rules prohibit the modification and/or revocation of elections before the beginning of the next plan year unless there is a qualifying change in status (i.e., change in marital status, employment status, work schedule, number of tax dependents, dependents' eligibility or worksite, or as otherwise defined by the IRS). The change must be a result of and correspond with the change in status (as determined by the employer/plan administrator).**

Filing a Claim

Claim Form

Some service providers may not have the ability to accept a debit card, so employee may want to confirm with provider beforehand. If a service provider does not accept the debit card, employee may pay for the services and submit a claim for reimbursement to HealthEquity, administer of the FSA benefits on behalf of Aflac. Claims may be submitted through employee's personal online account or by utilizing the mobile app. If an employee wishes to mail or fax a claim, employee would access a claim form from their personal online account. . Employee may also view the status of employee's account at any time. Documentation may also be required for some claims. Please maintain all receipts for FSA related services for the entire plan year.

Debit Card

Employees will receive a new debit card pre-loaded with their elections selected for the 2022 plan year. The debit card can be used for payment of eligible expenses. Most eligible services or items are automatically tabulated as FSA qualified when employee uses the debit card. As a reminder, over-the-counter items are no longer considered a qualified expense, unless prescribed by a physician. Employee may find a list of qualified and non-qualified expenses at http://irs.gov/publications/p502/index.html.

HERE'S HOW IT WORKS!

Employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $41.66 based on a 24 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving employee a tax savings of $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$30,000	$30,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$29,000	$30,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $5,698	- $5,895
After Tax Expenses	- $0	- $1,000
Spendable Income	$23,302	$23,105
Tax Savings	**$197**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds which remain in an FSA after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year, with the exception of the $570 carry over that may be allowed for the Healthcare Reimbursement FSA.* ***This is known as the "USE-IT OR LOSE-IT" rule.***

HealthEquity/Aflac | Agent: Frank D'Ascoli | Phone: (727) 514-7977
Fax: (877) 353-9256 | www.healthequity.com/wageworks

Retirement Benefit Summary

The City allows employee, upon retirement, to continue most benefits. Retirees who elect to continue City benefits will have premiums paid as an after-tax deduction from retiree's pension benefit. Retirees will be responsible for the full monthly premium cost for each benefit chosen (the City does not subsidize any portion of benefits for retirees). Upon retiring, if the retiree opts-out of coverage, retiree will no longer be eligible to participate in the City's plans.

Retirees will not be able to continue Flexible Spending Accounts (which may be continued through COBRA) and the Life insurance (which may be continued through direct payment to the provider).

Disability Retirement Benefit

The City allows retirees to apply for non-work related disability benefit. This benefit matches the active employee disability benefit but is only available upon retirement if employee has completed at least 10 years of pensionable service.

Retirees also may apply for work related disability benefit. This benefit will either match the active employee disability benefit or a minimum percentage of the final monthly compensation (42% for Non-Hazardous Duty or 66 2/3% for Grandfathered and Hazardous Duty participants) whichever is greater, as long as they are participating in the plan.

Pension Benefits

The City Employees' Pension Plan is an IRS-qualified, defined benefit plan, self-administered by the City and created for the sole purpose of providing retirement benefits to its participants. The contribution and benefit will depend on employee's job classification and participation date, prior to retiring.

Please Note: *The reference "Grandfathered" is defined as an employee who was eligible for normal retirement and contributing to the pension prior to the ordinance changes on 1/1/13.*

How much does employee contribute to the pension?

- **Grandfathered** - Participants contribute 8% of pensionable earnings, including special pays and overtime.
- **Non-Hazardous Duty** - Participants contribute 8% of base compensation.
- **Hazardous Duty** - Participants contribute 10% of pensionable earnings, including special pays and overtime (up to 300 hours per calendar year).

The City contributes an amount determined annually by the plan actuary based on the plan's performance, (not less than 7% of basic compensation for all employees participating). All deductions are on a pre-tax basis. Employees participating in the pension plan do not contribute to Social Security (OASDI) during that time; although most do have Medicare (HI) taxes deducted.

Pension Benefits *(Continued)*

Participants may opt to elect other forms of retirement, each of which will be calculated at the actuarial equivalent of the normal form based on the biographical data of the participant and the beneficiary.

- **Joint and Survivor Annuity** - An annuity paid monthly for the life of the participant. Upon death, 100% paid to the surviving spouse, and if none, the surviving children under the age of 18, for a period of five (5) years, after which time the benefit is reduced by 50% for the life of the beneficiary or until the spouse remarries or the child reaches the age of 18, whichever comes first. (Non-Hazardous Duty employees, if employee is not Grandfathered, this option is not available).
- **Single Life Annuity** - An annuity paid monthly for the life of the participant.
- **10-Year Certain and Life Annuity** - An annuity paid monthly for the life of the participant with 120 payments guaranteed.
- **50, 75, 100 or 66 2/3% Joint and Survivor Annuity** - An annuity paid monthly for the life of the participant. Upon death, 50%, 75%, 100% or 66 2/3% is paid to the surviving beneficiary for life.

In addition to the above options, a Partial Lump Sum option is available. This allows retirees to receive 10%, 20% or 30% of their normal retirement benefit as a one-time lump sum payment received in the first pension benefit payment, with the monthly benefits reduced accordingly thereafter. This lump sum amount is eligible for rollover.

When can Employee retire on pension?

- **Grandfathered and Non-Hazardous Duty** *(hired before 1/1/13)* – Participants must either complete 30 years of pensionable service, 20 years of service and be at least age 55 or 10 years of service and be at least age 65.
- **Non-Hazardous Duty** *(hired after 1/1/13)* – Participants must either complete 25 years of pensionable service and be at least age 60 or complete 10 years of pensionable service and be at least age 65.
- **Hazardous Duty** – Participants must either complete 20 years of pensionable service or complete ten years of pensionable service and be at least age 55. (There is an early retirement option for Hazardous Duty participants, which pays as early as age 50 after ten years of pensionable service, with a 3% reduction for each year below the age of 55).

How is retirement benefit calculated?

- For **Grandfathered, all Hazardous Duty and Non-Hazardous Duty** *(hired before 1/1/13)* participants, the normal monthly benefit formula is: 2.75% multiplied by the number of years of credited service multiplied by final monthly average compensation.

Example:	
Final Avg. Compensation	$43,200
X Pension Factor	0.0275
X Credited Service	25
Annual benefit	$29,700
Monthly Benefit	**$2,475**

- For **Non-Hazardous Duty** *(hired after 1/1/13)* participants, the normal monthly benefit formula is: 2% multiplied by the number of years of credited service multiplied by final monthly average compensation.

Example:	
Final Avg. Compensation	$43,200
X Pension Factor	0.02
X Credited Service	25
Annual benefit	$21,600
Monthly Benefit	**$1,800**

Pension Benefits *(Continued)*

What if employee leaves the City before employee is eligible to retire?

- If employee has completed at least ten years of pensionable service, employee may vest interest in the plan and begin to collect a retirement benefit when employee would otherwise have been eligible, while working for the City.
- If employee has less than ten years of pensionable service or does not wish to vest, employee may elect to receive a refund of employee's contributions to the plan plus 5% simple interest.

What if employee passes away as an active employee?

- If employee has a named beneficiary on file, that person will be able to select either a refund of employee contributions or a monthly retirement benefit, depending on employee's preference and whether or not employee completed at least ten years pensionable service.
- If there is no beneficiary on file, a refund of contributions will be paid to employee's estate unless married or have minor children at the time of death, in which case they may receive a limited benefit.

What are the rules regarding a beneficiary to employee's pension benefit?

- Participants are encouraged to elect a beneficiary to be kept on file in the event of pre-retirement death. Until retirement, participants may elect to change the beneficiary at any time.
- After retirement, the beneficiary may be changed twice, depending on the option selected, which will result in a recalculation of the monthly benefit amount.
- Only one (1) beneficiary may be named at a time.

For more information regarding retirement benefits and options available, employee may visit the Launchpad and view the City Code of Ordinances which describes, in detail, the provisions of the retirement plans. Employee may also contact Alyssa Gagliardi, the Senior Pension Payroll Analyst, at (727) 562-4523 or Alyssa.Gagliardi@MyClearwater.com with additional questions, request an estimate or to make an appointment to complete retirement paperwork.

Claims, Billing & Benefit Assistance

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

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

Employee may contact a claims specialist by:

1. Email: cityofclearwater@gehringgroup.com

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

OR

2. Call: (800) 244-3696

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

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

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

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctors' names and addresses or prescription medications.

CLEARWATER

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EMPLOYEE BENEFITS | RISK MANAGEMENT

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Palm Beach Gardens, Florida 33410
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