THE VILLAGE OF

NORTH PALM BEACH

2025 | 2026 EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

	Human Resources	Human Resources Department	
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	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) Email: support@mybentek.com app.mybentek.com/npb
	Medical Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Mail Order Program	Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
HSA	**Health Savings Account**	HSA Bank	Customer Service: (800) 357-6246 www.hsabank.com
	Telehealth	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.mycigna.com
	Dental Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	EyeMed	Customer Service: (866) 939-3633 www.eyemed.com
FSA	**Flexible Spending Account**	UpSwing	Customer Service: (866) 676-3665 https://upswing.wealthcareportal.com
	Employee Assistance Program	Uprise Health	Customer Service: (800) 395-1616 www.uprisehealth.com/members
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Voluntary Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Long Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Supplemental Benefits	Colonial Life	Agent: Alejandro Villasuso Phone: (305) 978-3355 Customer Service: (800) 325-4368 www.coloniallife.com

Table of Contents

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.

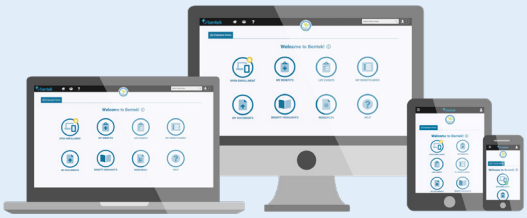
Introduction

The Village of North Palm Beach provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the 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 employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources.

Online Benefit Enrollment

The 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 **app.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, Monday through Friday during regular business hours 8:30am - 5:00pm.

To access Bentek using a mobile device, scan code.

Group Insurance Eligibility

The Village's group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the Village's medical, dental and vision insurance plans if they are full-time employees or part-time employees working a minimum of 30 hours per week or in excess of 1,560 hours within the established measurement period. Employees are eligible for the Village's Basic Life and AD&D insurance plan, Voluntary Life and AD&D insurance plan, and Long Term Disability if working a minimum of 40 hours per week. 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 for medical, dental and vision will continue through the end of month in which separation occurred. Other coverage may terminate on the last date of employment. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse/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 State Statute)
- 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 (taxable dependent) may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

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

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

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

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

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

Domestic Partner Coverage

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

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

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

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

Examples of Qualifying Events:

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

IMPORTANT NOTES

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

Medical Insurance

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

Medical Insurance
Cigna Open Access Plus (OAP) HDHP Plan
24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + One Dependent	$131.47
Employee + Family	$172.52

Medical Insurance
Cigna Open Access Plus In-Network (OAPIN) Only Plan
24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$64.40
Employee + One Dependent	$153.26
Employee + Family	$200.92

Cigna Healthcare | Customer Service: (800) 244-6224

Medical Plan Resources

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

Mobile App

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

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Summary of Benefits and Coverage

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

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

If there are any questions about the plan offerings or coverage options, please contact Human Resources at (561) 882-1155.

Telehealth

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

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

- ✓ Acne
- ✓ Allergies
- ✓ Cold and Flu
- ✓ Fever
- ✓ Headache/Migraine
- ✓ Rash
- ✓ Sore Throat
- ✓ Stomachache
- ✓ UTIs and More

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

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

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

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.*

***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.*

Network	Open Access Plus (OAP)	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network***
Single	$1,650	$3,000
Family	$3,300	$6,000
Coinsurance		
Member Responsibility	10%	40%
Plan Year Out-of-Pocket Limit		
Single	$3,000	$6,000
Family	$6,000	$12,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	10% After PYD	40% After PYD
Specialist Office Visit	10% After PYD	40% After PYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	10% After PYD	40% After PYD
X-rays	10% After PYD	40% After PYD
Advanced Imaging *(MRI, PET, CT)*	10% After PYD	40% After PYD
Outpatient Surgery at Surgical Center	10% After PYD	40% After PYD
Physician Services at Surgical Center	10% After PYD	40% After PYD
Urgent Care *(Per Visit)*	10% After PYD	40% After PYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After PYD	40% After PYD
Outpatient Hospital *(Per Visit)*	10% After PYD	40% After PYD
Physician Services at Hospital	10% After PYD	40% After PYD
Emergency Room	10% After PYD	10% After In-Network PYD
Mental Health/Alcohol & Substance Abuse		
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
Prescription Drugs *(Rx)*		
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 (OAPIN) Only Plan At-A-Glance

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

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.*

Health Savings Account

The Cigna Open Access Plus (OAP) High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollee 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.

2025-2026 Plan Year Funding*

Employee Only: $1,650

Employee + Family: $3,300

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).

- 2025 IRS Contribution Limitations: $4,300 (individual coverage); $8,550 (family coverage)
- 2026 IRS Contribution Limitations: $4,400 (individual coverage); $8,750 (family coverage)
- Individuals ages 55 and older can also make additional "catch-up" contributions up to $1,000 annually.

This maximum HSA amount would include any employer and employee contributions (pre-tax or post-tax). If employee is receiving an employer contribution, employee will want to account for this towards the annual IRS total maximum so employee does not over-contribute for the tax year. Guidelines regarding the HSAs are established by the IRS.

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

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, they may do so with pre-tax payroll deductions.
- HSA dollars may 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 may write a check or withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.
- Account holder can access HSA statement at any time to track account balance and activity online at www.hsabank.com.
- To be eligible to open an HSA, employee must be covered by a qualified high deductible health plan. Employee may not be covered under another medical plan that is not a qualified high deductible health plan including a plan the employee's spouse may have selected 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 the 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 the 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 may not contribute or receive HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

HSA Bank | Customer Service: (800) 357-6246 | www.hsabank.com

Health Savings Account: Understanding HSAs *(Continued)*

Question	HSAs Health Savings Accounts
What is an HSA?	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 http://www.irs.gov for a listing of 213 expenses.
How much is funded into the account?	**2025-2026 Plan Funding** **Employee Only: $1,650** **Employee + Family: $3,300** 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). • 2025 IRS Contribution Limitations: $4,300 (individual coverage); $8,550 (family coverage) • 2026 IRS Contribution Limitations: $4,400 (individual coverage); $8,750 (family coverage) • Individuals ages 55 and older can also make additional "catch-up" contributions up to $1,000 annually. ***Please Note:*** *Funding amount will be pro-rated for New Hires and for Qualifying Events making eligible tier level or plan changes.*
How are the funds accessed?	HSA funds can be accessed by: 1) Health Savings Account Visa card, or 2) Check book.
What happens to unused funds at the end of the 2025-2026 Plan Year?	The year-end balance remains in the HSA Account and continues to earn interest.
What happens to unused funds if employee discontinues participation in an HSA Plan, separates employment, or retires from the Village?	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.
What are some examples of qualified expenses that would be eligible for reimbursement?	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.
Can an employee have an HSA AND a Flexible Spending Account (FSA)?	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.

HSA Bank | Customer Service: (800) 357-6246 | www.hsabank.com

Dental Insurance

Cigna Dental DHMO Plan

The Village offers dental insurance through Cigna Healthcare 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 – Cigna DHMO Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + Family	$3.99

In-Network Benefits

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

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

Out-of-Network Benefits

The 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.

Mobile App

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

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

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

Cigna Dental DHMO Plan At-A-Glance

Network	Cigna Dental Care Access	
Calendar Year Deductible (CYD)	**In-Network Only**	
Per Member	Does Not Apply	
Per Family		
Calendar Year Maximum		
Class I Services: Diagnostic & Preventive Care	**Code**	**In-Network**
Office Visit	9430	$6 Copay
Routine Oral Exam *(2 Per Calendar Year)*	0150	No Charge
Routine Cleanings *(2 Per Calendar Year; Adult/Child)*	1110/20	No Charge
Bitewing X-rays *(2 Per Calendar Year)*	0274	No Charge
Complete X-rays *(1 Every 3 Years)*	0210	No Charge
Fluoride Treatments *(2 Per Calendar Year)*	1208	No Charge
Sealants *(Per Tooth)*	1351	$11 Copay
Emergency Care to Relieve Pain *(During Regular Hours)*	9110	$6 Copay
Class II Services: Basic Restorative Care		
Fillings *(Amalgam)*	2140	No Charge
Fillings *(Resin-based Composite; 2 Surfaces, Anterior/Posterior)*	2331/2392	No Charge/$75 Copay
Simple Extractions *(Erupted Tooth or Exposed Root)*	7210	$35 Copay
Root Canal Therapy *(Molar*)*	3330	$275 Copay
Surgical Removal of Tooth *(Impacted)*	7240	$100 Copay
General Anesthesia *(Each 15 Minutes; Deep Sedation)*	9223	$80 Copay
Class III Services: Major Restorative Care		
Crowns *(Porcelain Fused to Metal)*	6750	$210 Copay
Bridges *(Porcelain Fused to Metal)*	6240	$210 Copay
Dentures *(Upper/Lower)*	5110/20	$185 Copay
Class IV Services: Orthodontia - 24 Month Treatment Fee		
Benefit — Child *(Up to Age 19)*	8670	$1,464
Benefit — Adult	8670	$2,160
Treatment Planning/Records	8660	$125 Copay
Retention	8680	$285 Copay

Locate a Provider

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

Plan References

**Excluding final restoration.*

Important Notes

- *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.*
- *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.*

Dental Insurance

Cigna Dental DPPO Plan

The Village offers dental insurance through Cigna Healthcare 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 – Cigna Dental DPPO Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$12.05
Employee + Family	$40.80

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 the plan utilizes is the Total Cigna DPPO network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a 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 received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between Cigna's MRC and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

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 and out-of-network services combined. All services, including preventive, accumulate towards the benefit maximum, excluding orthodontia services. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

Mobile App

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

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

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

Cigna Dental PPO Plan At-A-Glance

Network	Total Cigna DPPO	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Plan Year Benefit Maximum		
Per Member *(Includes Class I, II, III, IX Services)*	$1,500	
Class I Services: Diagnostic & Preventive Care		
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)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam and Composite)*	Plan Pays: 80% After PYD	Plan Pays: 80% After PYD *(Subject to Balance Billing)*
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Periodontal Services		
Oral Surgery		
General Anesthesia		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After PYD	Plan Pays: 50% After PYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Class IX Services: Implants		
Benefit	Plan Pays: 50% After PYD	Plan Pays: 50% After PYD *(Subject to Balance Billing)*
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Dependent Children Up To Age 19)*	Plan Pays: 50% Deductible Waived	Plan Pays: 50% Deductible Waived *(Subject to Balance Billing)*

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 **Total Cigna DPPO** network.

Plan References

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

Important Notes

- *Two (2) routine cleanings per plan 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" 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 – EyeMed Select Plan

12 Monthly Deductions

Tier of Coverage	Employee Cost
Employee Only	$6.67
Employee + One Dependent	$12.69
Employee + Family	$18.62

Please Note: *The deduction is not every pay period.*

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 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.

Mobile App

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

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

EyeMed | Customer Service: (866) 939-3633 | www.eyemed.com

EyeMed Vision Select Plan At-A-Glance

Network		Select	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 Copay	Up to $35 Reimbursement
Contact Lens Fit and Follow-Up	Standard Lens	Up to $40 Allowance	Not Covered
	Premium Lens	10% Off Retail Price	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		$10 Copay	Up to $25 Reimbursement
Bifocal		$10 Copay	Up to $40 Reimbursement
Trifocal		$10 Copay	Up to $60 Reimbursement
Frames			
Allowance		Up to $120 Allowance 20% Off Balance Over $120	Up to $48 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $200 Reimbursement
Elective	Conventional	Up to $135 Allowance 15% Off Balance Over $135	Up to $95 Reimbursement
	Disposable	Up to $135 Allowance	Up to $95 Reimbursement

Locate a Provider

To search for a participating provider, contact EyeMed's customer service or visit 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 Accounts

The Village offers Flexible Spending Accounts (FSA) administered through UpSwing, previously Benefits Workshop. 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. There are three (3) types of FSAs:

- **Health Care FSA:** Available to eligible employees who are **not** enrolled in the Cigna Open Access Plus (OAP) 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 (OAP) 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 $3,300. 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 Health Care expenses eligible for reimbursement include, but not limited to, the following:

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

**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**.
- Employee can enroll in an FSA only during the Open Enrollment Period, New Hire Orientation, or Qualifying Life Events.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners healthcare expenses are not eligible for reimbursement in the employee FSA as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted using the member portal, mobile app, or by mail. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. UpSwing 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!

An employee earning $50,000 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 $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$50,000	$50,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$49,000	$50,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $9,628	- $9,825
After Tax Expenses	- $0	- $1,000
Spendable Income	$39,372	$39,175
Tax Savings	**$197**	

Mobile App

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

- File a Claim
- View Item for Eligibility
- View Account Activity
- Upload Receipts

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 Submission
Member Portal: https://upswing.wealthcareportal.com
Email: upswing_receipts@alegeus.com
Mailing Address: UpSwing Compliance & Technology Solutions
2630 W Broward Blvd, Suite 203-675, Ft Lauderdale, FL 33312

UpSwing
Customer Service: (866) 676-3665 | https://upswing.wealthcareportal.com
Email: info@upswing-tech.com

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 Uprise Health. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members/domestic partners free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee's or family member's well-being. Coverage includes six (6) visits with a specialist, per person, per issue per year, online material/tools and webinars. EAP offers counseling services on issues such as:

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

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor/manager), we 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. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Uprise Health
Customer Service: (800) 395-1616 | www.uprisehealth.com/members
Access Code: NORTHPALMBEACH

Basic Life and AD&D Insurance

Basic Term Life Insurance

The Village provides Basic Term Life insurance at no cost to all eligible employees through New York Life Group Benefit Solutions. Eligible employees will 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.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

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

Life Insurance Imputed Income

The IRS requires the imputed cost of employer paid Employee Basic Term Life insurance benefit in excess of $50,000 must be included as income and is subject to Federal, Social Security and Medicare taxes.

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

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

Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

Eligible employee may elect to purchase additional Life and AD&D insurance on a voluntary basis through New York Life Group Benefit Solutions. This coverage may be purchased in addition to the Basic Term Life and AD&D coverage. Voluntary Life insurance offers coverage for employee, spouse and/or dependent child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life and AD&D insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $100,000.**

- Units can be purchased in increments of $10,000 to a maximum of $500,000.
- Voluntary AD&D coverage matches the Voluntary Life amount elected.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 50% of the benefit amount at age 70

2025-2026 Open Enrollment: Eligible employees have the opportunity to purchase Voluntary Employee Life and AD&D insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $100,000.

Voluntary Spouse Life and AD&D Insurance

New Hires may purchase Voluntary Spouse Life and AD&D insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $30,000.**

- Employee must participate in the Voluntary Employee Life and AD&D plan for spouse to participate.
- Units can be purchased in increments of $5,000 to a maximum of $150,000.
- Voluntary Spouse AD&D coverage matches the Voluntary Spouse Life amount elected.
- Spouse coverage terminates when the spouse reaches age 70.

2025-2026 Open Enrollment: Eligible employees have the opportunity to purchase Voluntary Spouse Life and AD&D insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $30,000

Voluntary Life and AD&D Insurance Rate Table

Monthly Premium

Age Bracket *(Based On Age)*	Employee *(Rate Per $1,000 of Benefit)*	Spouse *(Rate Per $1,000 of Benefit)*
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	$0.880
65-69	$1.477	$1.474
70-74	$2.603	N/A
75-79	$9.814	N/A
>80	$9.785	N/A

Dependent Child(ren) Life Insurance

- Employee must participate in Voluntary Employee Life plan in order for dependent child(ren) to participate.
- Coverage may be purchased for dependent child(ren) 15 days to six (6) months in the amount of $500.
- Coverage may be purchased for eligible unmarried dependent child(ren), from six (6) months through age 19, or up to age 25 if a full-time student, in the amount of $10,000 not to exceed 50% of the employee's Voluntary Life coverage amount.
- Monthly cost for Voluntary Dependent Child(ren) Life coverage elected is $0.50 for $10,000 for any eligible dependent child(ren) enrolled, regardless of number of children.

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

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

Long Term Disability

The Village provides Long Term Disability (LTD) insurance at no cost to all eligible employees through New York Life Group Benefit Solutions. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

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 consecutive days prior to becoming eligibile 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 maximum benefit period is determined based on age at the time of disability.
- Benefits may be reduced by other income benefits.

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

Supplemental Benefits

Colonial Life offers a variety of supplemental benefit plans that may be purchased separately, on a voluntary basis and premiums paid by payroll deductions. Colonial Life pays money directly to employee, regardless of what other insurance plans employee may have. Children may be included in some plans up to age 26. Some plans require no network and there is annual wellness money available. Details regarding available Colonial Life plans and services are also available online at www.coloniallife.com.

Available plans include:

- ✓ **Hospital Indemnity Plan** - Pre-tax plan that covers employee and family by paying cash to employee, to alleviate medical costs such as copays and deductibles when accidents or illnesses happen.
- ✓ **Accident Plan** - Pre-tax plan with global coverage that pays cash to employee and family if injured in an accident.
- ✓ **Critical Illness Plan** - Post-tax plan that covers employee and family by paying a lump sum if covered member suffers from a severe ailment such as cancer, heart attack, stroke, coma, etc.
- ✓ **Gunshot Wound Plan** - Post-tax plan that pays out $5,000 if employee suffers a gunshot wound and is treated by doctor in hospital within 24hrs of the wound.
- ✓ **Short-Term Disability** - Post-tax plan that provides a benefit of 60% of employee's monthly income up to a benefit maximum of $4,000 per month, if employee becomes disabled due to an illness or injury off the job. The benefit is reduced by 50% if employee becomes disabled on the job due to workers compensation availability. If an employee's salary allows a monthly benefit over $4,000, medical underwriting will be required for approval with a benefit maximum of up to $6,500 per month. Employee can select a 3 month or 6 month benefit duration and an elimination period that works best for their needs. First Day Hospital Benefit is included which waives the elimination period of disability allowing benefits to begin day 1 if admitted and confined in a hospital for 24hrs.

Colonial Life | Customer Service: (800) 325-4368
Agent: Alejandro Villasuso | Phone: (561) 331-1289
alejandro@coloniallifesolutions.com | www.coloniallife.com
Benefits Education Portal: https://crm.avzbenefits.com/vnpb-oe-hello

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.

RISK strategies | GEHRING GROUP
A RISK STRATEGIES COMPANY

3500 Kyoto Gardens Drive, Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970 | www.gehringgroup.com

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