SOUTH FLORIDA WATER MANAGEMENT DISTRICT

2024
EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

	HR Benefits Analysts	SFWMD	Phone: (561) 686-8800 Email: HRBenefitsTeam@sfwmd.gov
	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) www.mybentek.com/sfwmd Email: support@mybentek.com
	Wellness	Cigna Healthcare	Onsite Cigna Well-Being Coordinator: Ratasha Iribarren Phone: (561) 682-6086 I Cell: (954) 304-6865 | Email: riribarr@sfwmd.gov
	Medical Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com Onsite Cigna Representative: Sikander Khan Phone: (561) 682-6052 | Email: skhan@sfwmd.gov
	Prescription Drug Coverage & Mail-Order Program	Cigna/Express Scripts Pharmacy	Customer Service: (800) 835-3784 www.mycigna.com
	Telehealth	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.mycigna.com
	Dental Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	Cigna Vision Care	Customer Service: (877) 478-7557 www.mycigna.com
FSA	**Flexible Spending Accounts**	HealthEquity	Customer Service: (877) 924-3967 www.WageWorks.com
	Employee Assistance Program	Cigna	Customer Service: (877) 622-4327 Register On: www.mycigna.com
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Voluntary Life Insurance	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Voluntary Short Term Disability	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Long Term Disability	New York Life Group Benefit Solutions	Customer Service (800) 362-4462 www.mynylgbs.com
	Supplemental Insurance and Discounts	Trustmark	New Enrollments - Customer Service: (888) 501-1280 Current Policy Holders - Customer Service: (800) 918-8877 | www.TrustmarkVB.com
		Legal Club	Customer Service: (800) 305-6816 www.legalclub.com
		Pet Benefit Solutions	Customer Service: (800) 891-2565 www.petbenefits.com/land/sfwmd
	Retirement Plans	Florida Retirement System (FRS)	Customer Service: (844) 377-1888 www.myfrs.com
		Fidelity Investments	Customer Service: (800) 343-0860 www.myfidelitysite.com/SFWMD

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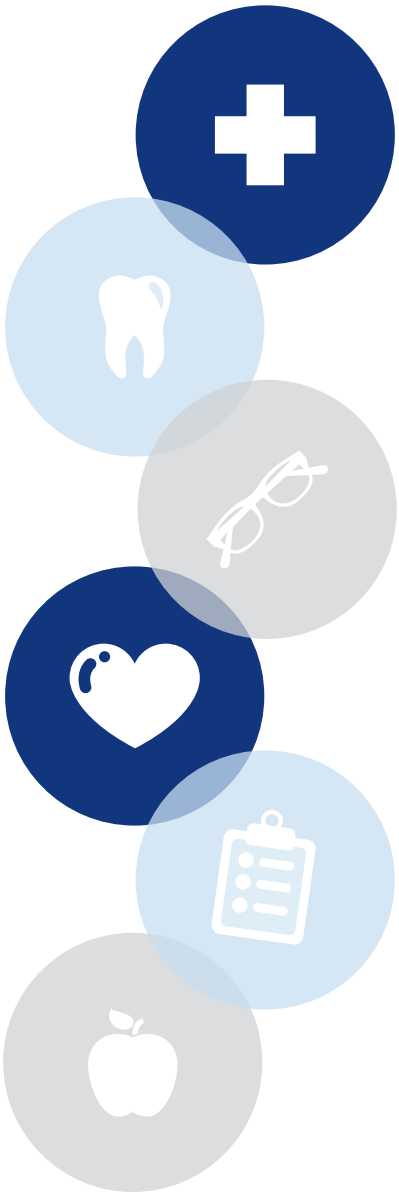


This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The South Florida Water Management District reserves the right to amend, modify or terminate the plan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

Introduction

South Florida Water Management District provides a comprehensive compensation package, which includes group insurance benefits, wellness programs and discounts. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to The District's Personnel Policies, applicable 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 the HR Benefits Team.

Whether you are new to the District or already a part of our team, please take the time to review the valuable benefits listed in this booklet. Be sure to complete your online enrollment information carefully and choose the benefit options that best meet your needs.

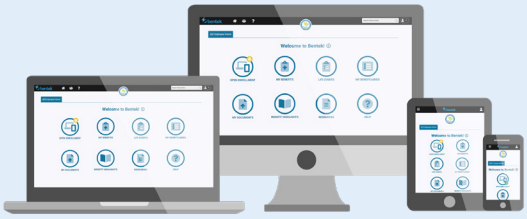
Your enrollment period is the only time that you are permitted to make benefit changes outside of an IRS qualified change in status. During enrollment, you can review your benefit plans, update your beneficiary and dependent information and make necessary adjustments. You must designate your life insurance beneficiaries in the Bentek system. Throughout the year, you may review your benefit plans and make changes to beneficiary designations.

We recommend that you log into the Bentek system well in advance of your enrollment deadline. If you have a question or need more information, please contact the HR Benefits Team. For technical support only, please call Bentek.

Online Benefit Enrollment

South Florida Water Management District 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 or New Hire Orientation.

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 and can review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/sfwmd**
  Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*
- ✓ To create a Bentek account, remember to add two (2) zeros in front of your Employee ID#. Example: 0012345
- ✓ 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 District's group insurance calendar year is January 1, 2024 through December 31, 2024.

Employee Eligibility

Coverage for District employees is effective the first of the month following one (1) full month of employment. For example, if employee is hired on April 11, coverage will be effective on June 1.

New Hire Enrollment

- Benefit elections must be completed before the effective date of coverage.

  Please Note: *Appropriate documentation is required for all dependents covered under any District insurance plan. Deadline to submit dependent documentation is 30 days from the effective date of employee elections. Submit copies of documentation to the HR Benefits Team.*

- Benefit-eligible employees, must elect coverage for any plan(s) in which they would like to enroll. Employees will be responsible for any and all premiums, deductibles, and copays that may apply. Enrollment in EAP, Basic Life, AD&D and Long Term Disability core coverage is automatic and paid for by the District.
- After the effective date of coverage, no changes, additions or cancellations of employee insurance coverage can be made unless the employee experiences a Qualifying Event, contacts the HR Benefits Team, and provides documentation within 30 days of event. (See Qualifying Events and Section 125).

Job Changes

Some job changes result in gain, loss or change in insurance benefits. See Qualifying Event section or contact the HR Benefits Team for more information. Employees should check their payroll stub following a job change to ensure payroll deductions continue without interruption.

Terminating and Retiring Employee

During the plan year, a terminating employee is covered until the last day of the month:

- In which employment ends.
- In which employee ceases being in a benefit eligible position.
- In which employee retires.
- However, Life and Disability insurance coverage ends with the last payroll premium payment.

Please contact the HR Benefits Team if further clarification is required.

Separation of Employment

If an employee separates employment from the District, medical insurance and most other benefits, will continue through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law. However, for Life and Disability insurance, coverage ends with the last payroll premium payment.

Chard Snyder | Customer Service: (888) 993-4646 | www.chard-snyder.com

Dependent Eligibility

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

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

Employees must provide supporting documentation to the HR Benefits Team when adding dependents to the plan. Dependents will be removed from the coverage if required documentation, such as marriage license or birth certificate, is not received by the District within 30 days of the Qualifying Event.

Dependent Age Requirements

Medical and Dental PPO Coverage: A dependent child may be covered through the end of 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 the age of 30, if the dependent meets all of 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 HMO Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26.

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

Group Insurance Eligibility *(Continued)*

Disabled Dependents

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

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

Proof of disability will be required upon request. Please contact the HR Benefits Team if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under employee's medical and dental PPO insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, imputed income must be reported on the employee's W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare taxes. Imputed income is the dollar value of insurance coverage attributable to covering each adult dependent child.

Contact **the HR Benefits Team** 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.*

Medicare Eligible

As long as Employee continues to participate in the District's group health insurance, Employee and/or spouse can delay enrollment in Medicare Part B until employee's retirement/separation from the District. It is important to contact Medicare to ensure enrollment in Part A.

Active employees turning age 65 should contact Social Security to sign up for Medicare Part A at least four (4) months prior to their 65th birthday.

To learn more, visit http://medicare.gov or speak with a Medicare representative 1-800-Medicare, (1-800-633-4227).

Documentation Requirements

All dependents must have an established legal relationship to the employee to be covered under the benefit program. The types of documentation accepted are as stated in the table below. Employees with dependents enrolled in the group insurance plans are advised that they will be required to comply with this process or continued coverage for such dependents may be jeopardized.

Dependent Relationship	Documentation Required
Spouse	• *Copy of legal government issued marriage certificate*
Dependent child(ren) under age 26	• *Copy of State issued birth certificate(s)* ***OR*** *copy of legal guardianship court documents listing the employee as legal guardian*
Step-child(ren) under age 26	• *Copy of State issued birth certificate(s)* • ***AND*** *the appropriate dependent child documentation listed above*
Child(ren) under legal guardianship, or custody under age 26	• *Copy of court documents showing legal guardianship* ***OR*** *legal custody documentation*
Child(ren) adopted or in the process of adoption under age 26	• *Copy of court documents of the legal adoption showing relationship to and placement in the employee's house* ***OR*** *adoption certificate*
Child(ren) age 27-30	• *Copy of state issued birth certificate(s) or legal guardianship court documents, listing the employee or spouse as parent/legal guardian* • ***AND*** *Overage Dependent Affidavit signed by employee*

Please Note: *Religious documents and registration cards are not acceptable proof. Employee may "black out" financial 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. Certain benefits, such as, Flexible Spending Accounts, cannot be changed outside of enrollment, even if a Qualifying Event has occurred.

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)
- A change in the place of residence of the employee, spouse, or dependent that affects eligibility to be covered under The District's plan, which includes moving out of an HMO service area.

Please Note: *Purchasing or dropping an individual policy for the employee or employee's dependent IS NOT a Qualifying Event and does not permit adding or dropping coverage for employee or employee's dependent from the group health plan outside of Open Enrollment.*

IMPORTANT NOTES

If employee experiences a Qualifying Event, **contact the HR Benefits Team within 30 days** 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.

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided on SFWMD employee portal (iWeb). The summary is an important item in understanding the benefit options. A free paper copy of the SBC document may be requested or is available as follows:

From:	The HR Benefits Team
Address:	3301 Gun Club Road West Palm Beach, FL 33406
Phone:	(561) 686-8800
Email:	HRBenefitsTeam@sfwmd.gov
Website:	www.mybentek.com/sfwmd

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 found on the mysfwmd homepage under the "Benefits tab".

If employees have any questions about the plan offerings or coverage options, please contact the HR Benefits Team.

Ride the Wave to Wellness

Ride the Wave to Wellness is a program sponsored in partnership by the South Florida Water Management District and Cigna to improve the health and well-being of District employees.

This program focuses on whole-person health: physical, emotional, social, financial, and environmental.

Employees may participate in various wellness events and programs. The program caters to all employees, at all levels and interests, and features educational and engaging activities such as:

- ✓ Annual Health Screenings
- ✓ Cooking Demos
- ✓ Fitness Classes
- ✓ Lunch and Learn Seminars
- ✓ Health and Wellness Fair
- ✓ Omada Diabetes Prevention Program
- ✓ Chronic Condition Coaching
- ✓ Cigna Total Behavioral Health
- ✓ Active and Fit Direct

Omada Diabetes Prevention Program

Cigna has partnered with Omada Health who is the nation's leading CDC-recognized provider of the Diabetes Prevention Program (DPP). Through its DPP, Omada delivers cost- effective prevention services for populations at risk or in the early stages of developing type 2 diabetes and other chronic conditions. This program is at no additional cost to employees and adult dependents on the Cigna medical plan. Those who qualify will learn how to adapt healthier eating habits, increase activity and reduce the risks of type 2 diabetes and heart disease. Contact your Onsite Cigna Well-Being Coordinator for additional information.

Cigna Healthcare
Onsite Cigna Well-Being Coordinator: Ratasha Iribarren
Phone: (561) 682-6086 I Email: riribarr@sfwmd.gov

Cigna Behavioral Programs

Whether you need help reducing stress, are feeling motivated to make a change in your life, or need to talk to someone, Cigna offers a variety of behavioral support tools and services to help ensure you get the support that works best for you.

To learn more or access services, visit www.mycigna.com, Coverage, Employee Assistance Program. You can also call (877) 231-1492 for referrals or go online, search the provider directory and obtain an authorization.

For links to iPrevail and Happify programs, visit the Wellness Page-Emotional Health on www.mycigna.com. You can also call Cigna's customer service at (800) 244-6224.

Health Coaching

Did you know your health plan comes with chronic condition health coaching? That means employees have access to a team of trained health professionals – including nurses, nutritionists, dietitians and certified health educators. And it's at no additional cost.

If employee or covered dependents are living with a chronic condition – such as diabetes, heart disease or depression – a health coach can work one-on-one over the phone to assist with the following benefits:

- ✓ Understand and follow the treatment your provider prescribes.
- ✓ Stay motivated to set and reach personal health goals.
- ✓ Access additional health and wellness resources.
- ✓ Get reliable answers and information based on specific health needs.

It's as easy as picking up the phone – either by answering when we call you, or calling Cigna directly at (800) 244-6224.

Medical Plan Resources

Cigna offers all enrolled members 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.

24 Hour Help Information Hotline (800) CIGNA-24

The Cigna 24-Hour Health Information Line provides access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do when a child has a fever in the middle of the night? Not sure if treatment from a doctor is necessary for an injury? There are over 1,000 topics in the Health Information Library that include free audio, video and printed information on aging, women's health, nutrition, surgery and specific medical conditions to help member weigh the risks and advantages of treatment options. The call is free and is strictly confidential.

Cigna 90 Now

Employees taking maintenance medications which are prescribed for chronic long-term conditions and are taken on a regular recurring basis, may now fill these prescriptions at a Cigna 90 Now pharmacy or through Cigna Home Delivery. Employees choosing to use a Cigna 90 Now pharmacy or through Cigna Home Delivery will help keep costs down and allows the District not to pass along additional cost to the employees. To find a Cigna 90 Now pharmacy, log on to www.mycigna.com.

Medical Plan Resources *(Continued)*

The myCigna Mobile App

The myCigna mobile app is an easy way to organize and access important health information. Anytime. Anywhere. Download it today from the App Store℠ or Google Play™. With the myCigna mobile app, member can:

- ✓ Find a doctor, dentist or health care facility
- ✓ Access maps for instant driving directions
- ✓ View ID cards for the entire family
- ✓ Review deductibles, account balances and claims
- ✓ Compare prescription drug costs
- ✓ Speed-dial Cigna Home Delivery Pharmacy™
- ✓ Store and organize all important contact info for doctors, hospitals, and pharmacies
- ✓ Add health care professionals to contact list right from a claim or directory search

Covered Treatment Options for Tobacco Cessation

The District offers coverage for tobacco cessation medications and nicotine replacement therapy with a $0 Copay. A prescription from your physician is required. Below is a list of covered products:

- ✓ Bupropion SR
- ✓ NicoDerm CQ
- ✓ Nicorelief
- ✓ Nicotrol
- ✓ Nicorette
- ✓ Zyban

Infertility Treatment

The District offers a basic benefit option for infertility treatments. This benefit is at no additional cost to Cigna members, and provides coverage for the following:

- ✓ Testing to determine the cause of infertility
- ✓ Treatment and/or procedures to restore fertility
- ✓ Artificial/intrauterine insemination

Healthy Rewards

Cigna's Healthy Rewards is provided automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Member 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

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 a wide range of minor conditions, including prescriptions. MDLIVE also provides access to Behavioral Virtual Health with licensed counselors and psychiatrists who can diagnose, treat and prescribe most medications for nonemergency behavioral conditions such as, addictions, bipolar disorder, child/adolescent issues, depression, eating disorders, stress, trauma/PTSD and many others.

The benefit is provided to all enrolled members. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care with a board-certified doctor via secure video chat and phone, without leaving your home or office, when needing immediate care for non-emergent medical issues. Telehealth should be considered when your primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Telehealth is a cost-effective alternative to a convenience care clinic, urgent care center or emergency room. 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. Members should pre-register on MDLIVE through Cigna. Telehealth services are only available for minor, non-life threatening conditions. A credit card is required for a temporary charge until the claim is processed.

Service Type	HMO Plan	OAPIN Plan
General Medicine	No Charge	No Charge

Register On:

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

Cigna Network HMO 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 Cigna Seamless HMO network.

Plan References

**The Cigna Seamless HMO network provides access to a broader network of doctors outside the standard Cigna HMO network.*

***Tier 1 Network Providers may provide a higher level of network benefits if services are received from a Tier 1 designated provider.*

****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 Seamless HMO network prior to receiving services.*

Important Notes

Members have direct access to care from the following specialties without a referral:

No Limitations:
- *OB/GYN*
- *Mental Health*
- *Substance Abuse*

6 Visit Limitations:
- *Dermatology*
- *Podiatry*
- *Chiropractic Care*

Save money on select specialty medications by enrolling into the SaveonSP Program. Cigna will contact members who are filling select specialty medications that are eligible for the SaveonSP program. Members enrolled under this program may incur $0 cost for specialty medications.

Network	Seamless HMO*
Calendar Year Deductible (CYD)	**In-Network**
Single	$0
Family	$0
Coinsurance	
Member Responsibility	0%
Calendar Year Out-of-Pocket Limit	
Single	$2,500
Family	$5,000
What Applies to the Out-of-Pocket Limit?	Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit *(PCP Designation is Required)*	$20 Copay
Specialist Office Visit**	Tier 1 Provider: $40 Copay / Non-Tier 1 Provider: $55 Copay
Physical Therapy	$55 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)****	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	No Charge
Outpatient Surgery in Surgical Center	No Charge
Physician Services at Surgical Center	No Charge
Urgent Care *(Per Visit; Waived if Admitted)*	$50 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	$250 Copay
Physician Services at Hospital	No Charge
Emergency Room *(Per Visit; Waived if Admitted)*	$200 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	$250 Copay
Outpatient Services *(Per Visit)*	No Charge
Outpatient Office Visit	$20 Copay
Prescription Drugs *(Rx)*	
Generic	$10 Copay
Preferred Brand Name	$20 Copay
Non-Preferred Brand Name	$40 Copay
Mail Order Drug *(90-Day Supply)* or Rx 90 Now Network†	2x Retail Copay

†Cigna 90 Now - Pharmacy Network for maintenance prescriptions. Visit cigna.com/rx90network to locate a pharmacy.

Cigna OAP In-Network Plan At-A-Glance

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	$150
Family	$300
Coinsurance	
Member Responsibility	20%
Calendar Year Out-of-Pocket Limit	
Single	$2,500
Family	$5,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$20 Copay
Specialist Office Visit*	Tier 1 Provider: $25 Copay / Non-Tier 1 Provider: $40 Copay
Physical Therapy	$40 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)***	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	20% After CYD
Outpatient Surgery in Surgical Center	20% After CYD
Physician Services at Surgical Center	20% After CYD
Urgent Care *(Per Visit)*	$35 Copay + CYD
Hospital Services	
Inpatient Hospital *(Per Admission)*	$250 Copay + 20% After CYD
Physician Services at Hospital	20% After CYD
Emergency Room *(Per Visit)*	$200 Copay + CYD
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	$250 Copay + 20% After CYD
Outpatient Services *(Per Visit)*	No Charge After CYD
Outpatient Office Visit	$25 Copay
Prescription Drugs *(Rx)*	
Generic	$10 Copay
Preferred Brand Name	$20 Copay
Non-Preferred Brand Name	$40 Copay
Mail Order Drug *(90-Day Supply)* or Rx 90 Now Network†	2x Retail Copay

†*Cigna 90 Now - Pharmacy Network for maintenance prescriptions. Visit cigna.com/rx90network to locate a pharmacy.*

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

**Tier 1 Network Providers may provide a higher level of network benefits if services are received from a Tier 1 designated provider.*

***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

Save money on select specialty medications by enrolling into the SaveonSP Program. Cigna will contact members who are filling select specialty medications that are eligible for the SaveonSP program. Members enrolled under this program may incur $0 cost for specialty medications.

Medical Insurance

The District offers medical insurance through Cigna Healthcare to benefit-eligible employees. The costs for coverage are listed in the premium tables below. **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 Network HMO Plan

Payroll Deductions - Regular Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$12.50	$25.00	$822.34	$847.34
Employee + 1 Child	$122.50	$245.00	$1,595.29	$1,840.29
Employee + 1 Child *(OAD)**	$142.50	$285.00	$1,591.98	$1,876.98
Employee + Spouse	$135.00	$270.00	$1,606.98	$1,876.98
Employee + Family	$140.00	$280.00	$1,709.35	$1,989.35
Employee + Family *(Employee + Children)*	$140.00	$280.00	$1,709.35	$1,989.35
Employee + Family *(OAD)**	$152.50	$305.00	$1,684.35	$1,989.35
Employee + Family *(OAD)* (Employee + Children)*	$152.50	$305.00	$1,684.35	$1,989.35

**OAD (Overage Dependent) = Dependent Child Over-age 26*

Medical Insurance – Cigna Network HMO Plan

Payroll Deductions - Managers and SES Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$5.25	$10.49	$836.85	$847.34
Employee + 1 Child	$18.41	$36.81	$1,803.48	$1,840.29
Employee + 1 Child *(OAD)**	$18.60	$37.20	$1,839.78	$1,876.98
Employee + Spouse	$18.77	$37.54	$1,839.44	$1,876.98
Employee + Family	$19.90	$39.79	$1,949.56	$1,989.35
Employee + Family *(Employee + Children)*	$19.90	$39.79	$1,949.56	$1,989.35
Employee + Family *(OAD)**	$19.59	$39.17	$1,950.18	$1,989.35
Employee + Family *(OAD)* (Employee + Children)*	$19.59	$39.17	$1,950.18	$1,989.35

**OAD (Overage Dependent) = Dependent Child Over-age 26*

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

Medical Insurance

The District offers medical insurance through Cigna Healthcare to benefit-eligible employees. The costs for coverage are listed in the premium tables below. **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 OAP In-Network Plan

Payroll Deductions - Regular Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$17.50	$35.00	$839.86	$874.86
Employee + 1 Child	$144.00	$288.00	$1,807.99	$2,095.99
Employee + 1 Child *(OAD)**	$188.25	$376.50	$1,841.03	$2,217.53
Employee + Spouse	$161.25	$322.50	$1,895.03	$2,217.53
Employee + Family	$169.50	$339.00	$2,011.53	$2,350.53
Employee + Family *(Employee + Children)*	$169.50	$339.00	$2,011.53	$2,350.53
Employee + Family *(OAD)**	$195.75	$391.50	$1,959.03	$2,350.53
Employee + Family (OAD) * *(Employee + Children)*	$195.75	$391.50	$1,959.03	$2,350.53

**OAD (Overage Dependent) = Dependent Child Over-age 26*

Medical Insurance – Cigna OAP In-Network Plan

Payroll Deductions - Managers and SES Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$5.42	$10.83	$864.03	$874.86
Employee + 1 Child	$20.96	$41.92	$2,054.07	$2,095.99
Employee + 1 Child *(OAD)**	$25.47	$50.93	$2,166.60	$2,217.53
Employee + Spouse	$22.18	$44.35	$2,173.18	$2,217.53
Employee + Family	$23.51	$47.01	$2,303.52	$2,350.53
Employee + Family *(Employee + Children)*	$23.51	$47.01	$2,303.52	$2,350.53
Employee + Family *(OAD)**	$29.67	$59.33	$2,291.20	$2,350.53
Employee + Family *(OAD)* (Employee + Children)*	$29.67	$59.33	$2,291.20	$2,350.53

**OAD (Overage Dependent) = Dependent Child Over-age 26*

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

Dental Insurance

Cigna DHMO Plan

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

Dental Insurance – Cigna DHMO Plan

Payroll Deductions - All Employee Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$4.91	$9.82	$26.37	$36.19
Employee + 1 Child	$15.95	$31.90	$40.65	$72.55
Employee + Spouse	$15.95	$31.90	$40.65	$72.55
Employee + Family	$24.65	$49.30	$63.63	$112.93
Employee + Family *(Employee + Children)*	$24.65	$49.30	$63.63	$112.93

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 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 provide benefits for services rendered by providers or facilities who do not participate in the Cigna Dental Care Access network or by an in-network provider not designated as the primary dental provider (unless referred by an employee's primary dental provider). Employee will pay out of pocket if they utilize any out-of-network providers.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Benefit Maximum

There is no benefit maximum.

IMPORTANT NOTES !

- *Children under age 13 may visit a pediatric dentist. Contact Cigna for a list of pediatric dentists in the network. Once the child reaches age 13, a referral with approved medical reasons by Cigna will be required prior to being seen by a pediatric dental provider.*
- *Coverage and age limitations may apply to some services. Check the plan summary or contact Cigna prior to having services rendered.*
- *The summary is provided as a convenient reference and additional charges may apply. For a full listing of covered services, exclusions, and stipulations, refer to the plan's Schedule of Benefits or contact Cigna's customer service for details specific to a procedure.*

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

Cigna DHMO Plan At-A-Glance

Network	Dental Care Access	
Calendar Year Deductible (CYD)	**In-Network Only**	
Per Member	Does Not Apply	
Per Family		
Waived for Class I Services?		
Calendar Year Benefit Maximum	**In-Network Only**	
Per Member	Does Not Apply	
Class I Services: Diagnostic & Preventive Care	**Code**	**In-Network**
Office Visit Fee	D9430	$0 Copay
Routine Oral Exam *(4 Per 12 Months)*	0150	$0 Copay
Routine Cleanings *(2 Per Calendar Year)*	1110/1120	$0 Copay
Bitewing X-rays *(2 Films)*	0272	$0 Copay
Complete X-rays *(1 Set Every 3 Years)*	0210	$0 Copay
Fluoride Treatments *(Child to age 19; 2 Per Calendar Year)*	1208	$0 Copay
Sealants - *Per Tooth*	1351	$0 Copay
Space Maintainers	1510	$0 Copay
Emergency Care to Relieve Pain *(During Regular Hours)*	9110	$0 Copay
Class II Services: Basic Restorative Care		
Fillings *(Amalgam)*	2140	$0 Copay
Fillings *(Composite; Anterior)*	2330	$0 Copay
Fillings *(Composite; Posterior - 3 Surfaces)*	2393	$82 Copay
Simple Extractions	7140	$12 Copay
Surgical Extractions *(Soft Tissue)*	7220	$21 Copay
Root Canal Therapy* *(Excluding Final Restoration)*	3330	$280 Copay
Periodontal Maintenance *(4 Per Calendar Year; Per Visit)*	4910	$66 Copay
General Anesthesia *(15 Minute Increments)*	9223	$95 Copay
Repairs to Dentures*	5510	$65 Copay
Class III Services: Major Restorative		
Bridges*	5213/5214	$575 Copay
Crowns*	2752	$355 Copay
Dentures*	5110/5120	$500 Copay
Class IV Services: Orthodontia		
Lifetime Maximum	Does Not Apply	Does Not Apply
Benefit — Child* *(Up to 19th Birthday)*	8670	$2,184 Copay
Benefit — Adult*	8670	$2,904 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 network.

Plan References

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

Important Notes

- *Each covered employee and family member(s) may receive two (2) routine cleanings per calendar year covered under the preventive benefit. Two (2) additional cleanings are available at the charge of a copay ($45 for adults/$30 for children).*
- *Referrals and prior authorizations are required to see a specialist (oral surgeon, periodontist, orthodontist, etc.) within the network.*
- *Waiting periods and age limitations may apply for some services.*

Dental Insurance

Cigna DPPO Plan

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

Dental Insurance – Cigna DPPO Plan

Payroll Deductions - All Employee Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$5.00	$10.00	$63.50	$73.50
Employee + 1 Child	$20.00	$40.00	$101.96	$141.96
Employee + Spouse	$20.00	$40.00	$101.96	$141.96
Employee + Family	$30.00	$60.00	$136.35	$196.35
Employee + Family *(Employee + Children)*	$30.00	$60.00	$136.35	$196.35

In-Network Benefits

The DPPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Total Cigna DPPO network. Employee will save money by utilizing a dental provider in this network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Please Note: *Total 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 will pay the out-of-network benefit plus the difference between the amount that Cigna reimburses (MRC) for such services and the amount charged by the dentist. This is known as balance billing (does not apply for out-of-network Cigna DPPO providers). Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The 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 preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the DPPO plan will pay for each covered member is $2,000 and the member will be responsible for all future charges until the next calendar year for in-network or out-of-network services combined. All services, including preventive services, accumulate towards the benefit maximum.

IMPORTANT

The summary is provided as a convenient reference and additional charges may apply. For a full listing of covered services, exclusions, and stipulations, refer to the plan's Schedule of Benefits or contact Cigna's customer service for details specific to a procedure.

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

Cigna DPPO Plan At-A-Glance

Network	Total Cigna DPPO	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	$50
Per Family	$150	$150
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member *(Includes Class I Services)*	$2,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Calendar Year)*		
Bitewing X-rays *(2 Per Calendar Year)*		
Complete X-rays *(1 Set Every 3 Calendar Years)*		
Emergency Care to Relieve Pain		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 85% After CYD	Plan Pays: 85% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Endodontics *(Root Canal Therapy)*		
Oral Surgery		
Periodontal Services		
Anesthetics		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 60% After CYD	Plan Pays: 60% After CYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$3,500	
Benefit	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(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 providers, please refer to the Out-of-Network Benefits section on the previous page.*

Important Notes

- *Each covered employee and family member(s) may receive up to two (2) routine cleanings per calendar year covered under the preventive benefit.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" 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.*
- *Cigna does not provide ID cards to DPPO members. Members should use their Medical ID card.*

Vision Insurance

Cigna Vision Plans

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

Vision Insurance – Cigna Core Vision Plan

Payroll Deductions - Regular Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$2.50	$5.00	$1.60	$6.60
Employee + 1 Child	$4.00	$8.00	$4.50	$12.50
Employee + Spouse	$5.00	$10.00	$2.50	$12.50
Employee + Family	$6.00	$12.00	$6.40	$18.40
Employee + Family *(Employee + Children)*	$6.00	$12.00	$6.40	$18.40

Vision Insurance – Cigna Core Vision Plan

Payroll Deductions - Managers and SES Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$0.00	$0.00	$6.60	$6.60
Employee + 1 Child	$0.00	$0.00	$12.50	$12.50
Employee + Spouse	$0.00	$0.00	$12.50	$12.50
Employee + Family	$0.00	$0.00	$18.40	$18.40
Employee + Family *(Employee + Children)*	$0.00	$0.00	$18.40	$18.40

Vision Insurance – Cigna Buy-Up Vision Plan

Payroll Deductions - All Employee Premiums

Tier of Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium	District Monthly Contribution	Total Monthly Premium
Employee Only	$5.00	$10.00	$7.80	$17.80
Employee + 1 Child	$10.00	$20.00	$13.70	$33.70
Employee + Spouse	$14.00	$28.00	$5.70	$33.70
Employee + Family	$21.50	$43.00	$6.70	$49.70
Employee + Family *(Employee + Children)*	$21.50	$43.00	$6.70	$49.70

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 employee and covered dependent(s) may select any network provider who participates in the Cigna Vision network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

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

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

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

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

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

Cigna Vision Plans At-A-Glance

Plan	Core Vision Plan		Buy-Up Vision Plan
Network	**Cigna Vision**		**Cigna Vision**
Services	**In-Network**	**Out-of-Network**	
Eye Exam	No Charge	Up to $40 Reimbursement	Up to $50 Allowance
Frequency of Services			
Examination	24 Months		12 Months
Lenses	24 Months		12 Months
Frames	24 Months		12 Months
Contact Lenses	24 Months		12 Months
Lenses			
Single	Covered at 100%	Up to $45 Reimbursement	Up to $101 Allowance
Bifocal		Up to $90 Reimbursement	Up to $203 Allowance
Trifocal		Up to $126 Reimbursement	Up to $284 Allowance
Frames			
Allowance	Up to $150 Allowance	Up to $45 Reimbursement	Up to $150 Allowance
Contact Lenses*			
Non-Elective; Medically Necessary	Covered at 100%	Up to $90 Reimbursement	Up to $203 Allowance
Elective *(Fitting, Evaluation & Follow-up)*	Up to $100 Allowance	Up to $90 Reimbursement	Up to $203 Allowance

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 the Cigna Vision 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.*
- *Vision Buy Up benefits are provided on a yearly basis.*
- *Vision Core benefits are provided every other year.*
- *Benefit waiting period is based on date of service and not on plan change effective date.*
- *Eligibility for eye examinations and materials are based on the calendar year the services were last received and are tracked across vision plans.*

Flexible Spending Accounts

The District offers Flexible Spending Accounts (FSA) administered through HealthEquity/WageWorks. The FSA plan year is from January 1 to December 31.

Participating employee must re-elect the dollar amount to be deducted each plan year.
There is no automatic enrollment for an FSA. Employees who do not re-elect this benefit during Open Enrollment will not have an FSA for the upcoming plan year.

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

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,050. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

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

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

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if the participating employee is single or married and files 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 adults.

Please note, if a family's 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:

- The participants dependent, and
- 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 the participant's paycheck for the Dependent Care FSA.

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

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

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

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- The Health Care FSA has a **90 day run out** period at the end of the calendar year in which to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year **January 1 – December 31, 2024**. **For 2024, the run out period ends March 31, 2025.**
- Only Health Care FSA allows a grace period at the end of the plan year. The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends. Once the grace period ends, any unused funds still remaining in the account will be forfeited. **The 2024 grace period ends on March 15, 2025**.
- When a plan year and grace period ends, and all claims have been filed, unused funds will be forfeited and will not be allowed to be returned.
- Employee can enroll in either or both FSAs only during the Open Enrollment Period or New Hire Orientation.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible in the employee FSA as federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail, fax, online or through the HealthEquity/WageWorks mobile app. 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 can request 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. **HealthEquity/WageWorks may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the District.** This card will not expire at the end of the benefit year. Please keep the issued card for use next year. The debit card is only for medical expenses, not dependent care.

HealthEquity/WageWorks
4609 Regent, Suite 100, Irving, TX 75063
Claims: help@wageworks.com

HERE'S HOW IT WORKS!

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $38.46 based on a 26 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

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

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year.* ***This rule is known as "use-it or lose-it."***

Using a Smartphone or Mobile Device

With EZ Receipts mobile app from HealthEquity/WageWorks, employees can file and manage reimbursement claims and receipts with a click of a smartphone or mobile device camera, from anywhere.

Use EZ Receipts:

- **Download the app from www.WageWorks.com, Apple App Store or Google Play Store.**
- **Log into account.**
- **Choose the type of receipt from the simple menu.**
- **Enter required information regarding the transaction.**
- **Use a smartphone camera or device to capture the documentation.**
- **Submit the image and details to HealthEquity/WageWorks.**

HealthEquity/WageWorks
Customer Service: (877) 924-3967 | www.WageWorks.com

Employee Assistance Program

The District cares about their employees well being on and off the job and provides all benefit-eligible employees and each family member an Employee Assistance Program (EAP) through Cigna at no cost.

What is an Employee Assistance Program?

An Employee Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that negatively affect well-being such as:

- ✓ Stress Management
- ✓ Parenting Problems
- ✓ Marital Problems
- ✓ Relationship Issues
- ✓ Substance Abuse
- ✓ Critical Incident Debriefing
- ✓ Child Care
- ✓ Elder Care
- ✓ Financial Services

How Do Employees Access EAP Benefits?

The EAP provides up to six (6) counseling sessions per occurrence for short-term problem resolution. Conditions that require long-term treatment may be referred to employee's medical plan. The EAP also provides unlimited phone consultation with an EAP professional available 24 hours a day, seven (7) days a week at the customer service number given below.

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 or 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.

To Access Services

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

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

Basic Life and AD&D Insurance

Basic Term Life Insurance

The District provides benefit-eligible employees, working a minimum of 25 hours per week, a Basic Term Life insurance benefit through New York Life at no cost to the employee as follows:

Regular Full-Time Employees

The Life insurance benefit amount is equal to one (1) times the employee's annual salary rounded up to the nearest $1,000, to a maximum of $200,000. Employees will be required to pay imputed income tax for coverage over $50,000.

Managers/Select Exempt Service Employees

The Life Insurance benefit amount is equal to two (2) times employee's annual salary rounded up to the nearest $1,000, to a maximum of $400,000. Employees will be required to pay imputed income tax for coverage over $50,000.

The Life insurance benefit carries an Accelerated Living Benefit. This allows an employee to apply for a living benefit if diagnosed with a terminal condition. The amount of the term life insurance under the policy will be reduced by the amount of living benefit paid to you and by any administrative fees.

Accidental Death & Dismemberment Insurance

Also, at no cost to employee, The District provides Accidental Death & Dismemberment (AD&D) insurance to eligible employees working a minimum of 25 hours per week. The AD&D pays in addition to the Basic Term Life insurance when a death occurs as a result of an accident. The AD&D benefit amount is equal to one (1) times the employee's annual salary rounded up to the nearest $1,000, to a maximum of $50,000.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- › Reduces to 65% of the benefit amount at age 65
- › Reduces to 45% of the benefit amount at age 70
- › Reduces to 30% of the benefit amount at age 75
- › Reduces to 20% of the benefit amount at age 80

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

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

Voluntary Life Insurance

Voluntary Employee Life Insurance

Employees regularly working a minimum of 25 hours per week may elect to purchase Voluntary Life insurance via payroll deduction through New York Life. This Voluntary Life insurance may be purchased at different benefit amounts depending on eligibility classifications. All employee classifications also have the option to purchase spouse and/or children at different levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $350,000.**

- Units can be purchased in increments of $10,000 to the lesser of five (5) times salary or $500,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 45% of the benefit amount at age 70
  - Reduces to 30% of the benefit amount at age 75
  - Reduces to 20% of the benefit amount at age 80
- Calculate Bi-Weekly Premium Deduction:
  Benefit Amount ÷ $1,000 x Rate (See Table) x 12 ÷ 24 = Deduction
- **2024 Open Enrollment:** Enrolled employees may increase coverage up to but not exceeding the Guaranteed Issue amount of $350,000 without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). All others will need to complete an EOI. Please contact Human Resources for additional information

Voluntary Spouse Life Insurance

New Hires may purchase Voluntary Spouse Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $50,000.**

- Employees must first elect Voluntary Employee Life insurance in order to purchase Voluntary Spouse Life coverage.
- Units can be purchased in increments of $5,000 not to exceed a maximum of $250,000 or 100% of employee's Voluntary Life insurance amount.
- Rate is based on employee age.
- Benefit amounts are subject to the voluntary employee life age reduction schedule based on the employee's age.
- Calculate Bi-Weekly Premium Deduction:
  Benefit Amount ÷ $1,000 x Rate (See Table) x 12 ÷ 24 = Deduction
- **2024 Open Enrollment:** Enrolled employees may increase coverage for spouses up to but not exceeding the Guaranteed Issue amount of $50,000 without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI). All others will need to complete an EOI. Please contact Human Resources for additional information.

Voluntary Employee and Spouse Life Rate Table

Age	Employee and Spouse *(Rate Per $1,000)*
<20-34	$0.11
35-39	$0.12
40-44	$0.16
45-49	$0.26
50-54	$0.43
55-59	$0.72
60-64	$1.01
65-69	$1.73
70-99	$6.75

Voluntary Dependent Child(ren) Life Insurance

- Employee must first elect Voluntary Employee Life insurance in order to purchase Voluntary Dependent Child(ren) Life coverage.
- Coverage may be purchased for dependent child(ren) birth to six (6) months in the amount of $500.
- Coverage may be purchased for dependent child(ren) age six (6) months to 30 years in flat benefit amounts of $5,000, $10,000 or $25,000.

Voluntary Dependent Child(ren) Life Rate Table

Benefit Amount	Bi-Weekly Premium *($0.15 Rate Per $1,000)*	Monthly Premium *($0.30 Rate Per $1,000)*
$5,000	$0.38	$0.75
$10,000	$0.75	$1.50
$25,000	$1.88	$3.75

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

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

Voluntary Short Term Disability

The District offers Short Term Disability (STD) insurance through New York Life to all benefit-eligible employees working a minimum of 25 hours per week. The STD benefit pays employee a percentage of weekly base earnings if employee becomes disabled due to an illness or non-work related injury.

Voluntary Short Term Disability (STD) Benefits

- STD offers a benefit of 60% of employee's weekly pre-disability earnings subject to a benefit maximum of $1,500 per week.
- Employee must be disabled for 14 consecutive days due to illness or a non-work related injury prior to becoming eligible for benefits, (known as the elimination period).
- Benefit payments will commence on the 15th day of disability.
- Maximum benefit period is 26 weeks (includes elimination period).
- Employee deemed unable to return to work after the STD 26-week maximum period is exhausted, may be eligible to transition to Long Term Disability (LTD) insurance.
- Benefit may be reduced by other income.
- Disability benefits may be taxable.

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

Long Term Disability

The District offers Core and Buy-up Long Term Disability (LTD) insurance through New York Life to all benefit-eligible employees working a minimum of 25 hours per week. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Core Long Term Disability (LTD) Benefits

- Eligible employee is automatically enrolled in this coverage at no cost to the employee.
- LTD provides a benefit of 60% of employee's monthly pre-disability earnings up to a benefit maximum of $2,300 per month.
- Employee must be disabled for 180 days prior to becoming eligible for the LTD benefit (known as elimination period).
- Benefit payments will commence on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if returning to work on part-time basis.
- Benefit may be reduced by other income.
- Maximum benefit period depends on employee age at the time of disability as shown below.
- Disability benefits may be taxable.

Vountary Buy-Up Long Term Disability (LTD) Benefits

- Buy-Up LTD is only offered to employee with a salary that exceeds $46,000.
- Provides a benefit of 60% of employee's monthly pre-disability earnings up to a benefit maximum of $7,500 per month.
- Employee must be disabled for 180 days prior to becoming eligible for the LTD benefit (known as elimination period).
- Benefit payments will commence on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if returning to work on part-time basis.
- Benefit may be reduced by other income.
- Maximum benefit period depends on employee age at the time of disability as shown below.
- Disability benefits may be taxable.

Please Note: *The Buy-up option will require Evidence of Insurability (EOI) unless employee enrolls within 31 days of eligibility or an annual salary increase in excess of $46,000.*

Benefit Duration Period

If disability occurs at age 62 or younger, the benefit will continue to age 65 or the date the 42nd monthly benefit is payable, if later. Please see table below if age of disability is above 63:

Age of Disability	63	64	65	66	67	68	69+
Number of Months Benefits Paid	36	30	24	21	18	15	12

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

Supplemental Insurance and Discounts

Trustmark

Trustmark offers a variety of voluntary supplemental insurance plans to full-time benefit-eligible employees. These may be purchased separately on a voluntary basis and premiums paid by payroll deduction. Available plans include:

Accident Insurance Benefit

Trustmark Accident Insurance is an affordable voluntary solution that helps pay for unexpected health care expenses due to non-occupational accidents. Accident insurance pays benefits directly to the employee in addition to any other coverage they have. Benefits include initial care, injuries and follow-up care of a covered accident. The plan is portable after employee's first payroll deduction.

Accident Insurance also offers a Wellness Benefit. A $100 benefit is given to offset the cost of going to the doctor for routine physicals, immunizations and health screening tests, regardless of other coverage. The benefit provides a maximum of two (2) visits per person and a 60-day waiting period applies. To inquire about eligible tests, please contact customer service.

Critical Illness Insurance

Critical Illness Insurance offered to employees through Trustmark provides a benefit ranging from $5,000 - $100,000. Funds are provided directly to the covered person and can be used at their own discretion such as travel, room and board, child care or treatment options not covered by traditional insurance. The plan is portable after the first payroll deduction.

Critical Illness Insurance also includes an Optional Health Screening Benefit. The cost of one (1) screening test per calendar year ($50 or $100 benefit). To inquire about a specific screening, please contact customer service.

Universal Life Insurance

Trustmark offers a variety of additional flexible benefits though Universal Life Insurance for eligible employees and covered family members. This plan complements any group term life insurance plan. The flexible benefits include, death benefit, LTC Living Benefits and Interest-Earning Cash Value. This plan comes with an EZ Value Plan option allowing for automatic increases in your coverage annually on each of the first five (5) policy anniversaries. The increase is equal to the amount of protection an additional $1.00 per week of deduction would purchase.

Trustmark

New Enrollments
Customer Service: (888) 501-1280

Current Policy Holders
Customer Service: (800) 918-8877
Claims Phone: (877) 201-9373
www.TrustmarkVB.com

Legal Club

The District offers employees the opportunity to participate in a voluntary pre-paid Family Protection Plan provided by Legal Club. By enrolling in this plan, a participant will have direct access to attorneys who will provide legal assistance, for a variety of situations including:

- ✓ Free & Discounted Legal Care
- ✓ Tax Preparation & Advice
- ✓ Financial Education & Credit Counseling
- ✓ Identity Theft Solutions
- ✓ Life Events™ Counseling

This plan also offers identity theft protection to participants with consultations, privacy and security monitoring, identity monitoring and restoration benefits.

The cost to the employee to participate in this legal plan is $14 per month. This includes coverage for the entire household including spouse, domestic partners, dependent children and any dependent individual living in the member's home, such as a parent or grandparent, regardless of the number of eligible dependents enrolled in the plan.

Free Membership

After six (6) continuous years of participation in Legal Club, members from qualified groups will no longer be required to pay for access to free and discounted LEGAL benefits. Payroll deductions will continue at a significantly reduced rate so that member can access the other NON-LEGAL related services.

Legal - Family Protection Plan
Premium Payroll Deductions

Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium
Family Protection Plan	$7.00	$14.00

Legal Club
Customer Service: (800) 305-6816 | www.legalclub.com

Supplemental Insurance and Discounts *(Continued)*

Pet Benefit Solutions

The District provides employees the opportunity to purchase Pet Benefit Solutions, a Veterinary Discount Plan, on a voluntary basis. Participating Pet Benefit Solutions providers offer a 25% savings on all in-house veterinary medical care. This includes office visit, exam, shots, surgery, x-rays and more. Visit petassure.com/search for a complete list of local providers. Pet Benefit Solutions is not insurance, therefore there are no exclusions. An employee can enroll any pet, any breed, any age and in any health condition; including pets with pre-existing and hereditary conditions. Also, included at no additional cost is ThePetTag, Pet Assure's 24/7 Lost Pet Recovery Service. ThePetTag that helps thousands of lost pets reunite with their families. The Pet Assure Veterinary Discount Plan can be purchased for $9 per month, regardless of how many covered pets.

Pet Discount Program

Premium Payroll Deductions

Coverage	Employee Bi-Weekly Premium	Employee Monthly Premium
Pet Benefit Solutions	$4.50	$9.00

Pet Benefit Solutions

Customer Service: (800) 891-2565 | www.petbenefits.com/land/sfwmd

Florida Retirement System

Florida Retirement System (FRS)

The District participates in the Florida Retirement System (FRS) Plan for all full-time employees working in regularly established positions. Positions that are scheduled and budgeted as temporary or seasonal are not eligible.

Members are eligible for the Pension Plan benefit with six (6) years of service vesting if enrolled before July 1, 2011 or with 8 (eight) years of service vesting if enrolled on or after July 1, 2011. Investment Plan members are vested after one (1) year of service. One of the special features of membership in the FRS is portability — the ability to keep the retirement credit when an employee changes FRS employers. This means if an employee separates employment with one (1) FRS employer, and later goes to work with any other FRS employer, their service credit will be retained from their previous job and combined with the new service credit. If you are employed in a regularly established position (one (1) covered for retirement) on or after July 1, 2011, you must pay the three (3) percent employee contribution unless you are participating in DROP or you are re-employed retiree who is not eligible for renewed membership.

The monthly benefit payment an employee receives when they retire depends on their years of creditable service, retirement age, average final compensation, and the retirement plan options you select. The formula for calculating the monthly benefit will be provided upon enrollment by FRS.

Category	Enrollment* Date Prior to July 1, 2011	Enrollment* Date After July 1, 2011
Normal Retirement Criteria	30 years of FRS service regardless of age	33 years of FRS service regardless of age
Service Credit Age	Age 62 and 6 years of FRS service	Age 65 and 8 years of FRS service
Average Final Compensation	Average of the 5 highest years of compensation	Average of the 8 highest years of compensation
DROP Participation	Eligible upon meeting normal retirement criteria above	Eligible upon meeting normal retirement criteria above
DROP Interest Rate	6.5% interest paid on DROP accounts annually	4% interest paid on DROP accounts annually

**Enrollment is considered creditable service from any FRS employer.*

FRS | Customer Service: (844) 377-1888 | www.myfrs.com

Voluntary Retirement Plan

Fidelity Investments

The District offers a 457(b) Deferred Compensation savings plan through Fidelity Investments.

457(b) Plan

Employees may set aside pre-tax dollars toward retirement savings through automatic payroll deductions, which reduces taxes that are paid out today. The money contributed to this type of account, including earnings, accumulates on a tax-deferred basis. Withdrawals of contributions and earnings are subject to Federal and State (if applicable) income taxes in effect at the time of withdrawal.

Additional Benefits:

1. Rollover eligible savings from a previous employer into this plan as well as 401(k), 401(a), 403(b), 457(b) or IRAs.
2. Take a loan from the account with a minimum vested account balance of $2,000, a loan can be requested for any reason for up to 50 percent of the vested account balance.
3. A Roth post-tax payroll deduction investment option is also available, please contact customer service for additional information.

2023 Limitations

457(b)	
Annual Deferral Limit for 457 Plans	$22,500
"Age 50" Catch-Up Limit	$7,500 ($30,000 Total)

Please Note: *These limits are set by the IRS and participants may adjust their contribution amounts accordingly.*

There is no employer matching for this program, and is subject to minimum and maximum participation amounts. Employees can choose to contribute to the 457(b) Deferred Compensation plan by contacting Fidelity customer service or logging into Fidelity online.

Fidelity Investments
Customer Service: (800) 343-0860 | www.myfidelitysite.com/SFWMD

Please Note: *Be sure to maintain your list of beneficiaries for each benefit that you choose. A separate list of beneficiaries is required for every plan. For example, each retirement plan and life insurance policy is separate.*

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

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