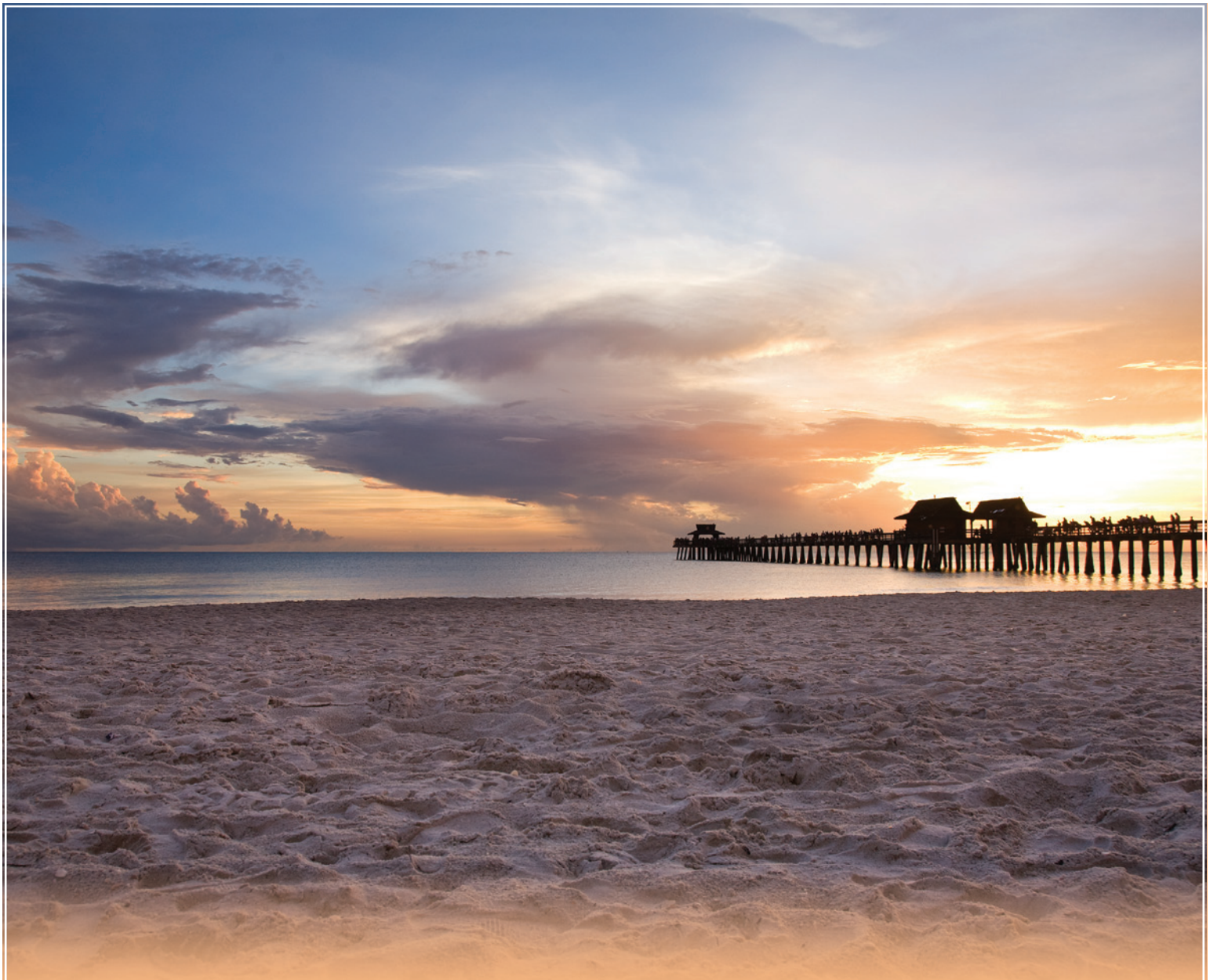

2011-2012

City of Naples

EMPLOYEE BENEFIT HIGHLIGHTS

IMPORTANT CONTACT INFORMATION		
City	**Contact Name**	**Contact Information**
Human Resources	Human Resources	(239) 213-1810 www.naplesgov.com
Service Providers		
Health Insurance	CIGNA	(800) 244-6224 www.mycigna.com
Pharmacy / Mail Order Prescriptions	CIGNA / Tel-Drug	(800) 835-3784 www.teldrug.com
Dental Insurance	CIGNA	(800) 244-6224 www.mycigna.com
Vision Insurance	EyeMed	(866) 723-0513 www.eyemedvisioncare.com
Flexible Spending Accounts	CIGNA	(800) 244-6224 www.mycigna.com
Basic, AD&D and Voluntary Life Insurance	Aetna	See Human Resources
Long Term Disability	Aetna	See Human Resources
Employee Assistance Program	Horizon Health EAP Services	(800) 272-7252 www.horizoncarelink.com Username: CON Password: CON
Online Benefit Enrollment / Website	BenTek Support	(888) 5-BenTek (523-6835) www.mybentek.com/naples
Retirement Plans		
ICMA	Tony Chifari	(866) 886-8025 www.achifari@icmarc.org
AIG / VALIC	Ryan Austin	(239) 292-7433 www.ryan.austin@aigretirement.com
Nationwide	Ron LeClair	(239) 594-8931 www.LeClair@nationwide.com

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Introduction

The City of Naples provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to the City's Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If you require further explanation or need assistance with benefit questions or claims processing, please refer to the customer service telephone numbers under each benefit description heading or contact Human Resources using the contact information provided.

2011 Plan Year News

The City has the following plan options effective October 1, 2011 through September 30, 2012.

Health Insurance — CIGNA is our medical insurance provider and offers the following plan:
- Consumer Driven Health Plan (CDHP) with a Health Reimbursement Account (HRA).

Dental Insurance — CIGNA is our dental insurance provider.

Vision — EyeMed is our vision insurance provider.

Flexible Spending Accounts (FSA)
- CIGNA is our Flexible Spending Account (FSA) administrator.
- Any employee wishing to contribute to an FSA can do so during open enrollment.
- Your previous election amount does not automatically continue to the new plan year and **MUST** be reelected.

Voluntary Life Insurance and Accidental Death & Dismemberment (AD&D)
Employees can purchase voluntary life insurance for themselves, spouse, and/or children through Aetna. Employees can also purchase voluntary AD&D for themselves through Aetna. If interested in purchasing, you will need to complete and submit an Evidence of Insurability Form (EOI) to Human Resources.

Employer Provided Plans
- Employee Dental Insurance through CIGNA / single coverage only.
- Basic Life and AD&D Insurance through Aetna.
- Long Term Disability through Aetna (Police and Fire excluded from LTD coverage).
- Employee Assistance Program (EAP) through Horizon Health EAP Services.

Online Enrollment

BenTek
Technical Support - E-mail: support@mybentek.com
Technical Support - Telephone: (888) 5-BenTek (523-6835)

The City provides an electronic enrollment option through BenTek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to make group insurance benefit elections and changes online during the annual open enrollment.

To access the Employee Benefits Center during open enrollment:

- Log on to https://www.mybentek.com/naples
- If you've forgotten your username and/or password, click on the link "Forgot Username" or "Forgot Password" and follow the instructions.
- Enter BenTek to review current elections, learn about your benefit options, and make any elections or changes.
- You may also update your life insurance beneficiary designation(s).

You have the option to print out your enrollment confirmation statement containing all your benefit elections for you and your family, including your life insurance beneficiary designations.

Accessible 24 hours a day during the open enrollment process, information about all of your employee benefits election options, including premiums and carrier contact information, is also available to help you make informed decisions. You can also log on to the EBC at any time to review your benefits, access carrier links, update life insurance beneficiaries.

If any technical questions arise while visiting the EBC, please e-mail BenTek Support at **support@mybentek.com** or call **(888) 5-BenTek (523-6835)**, Monday through Friday, during regular business hours.

To access your group insurance benefits online, log on to https://www.mybentek.com/naples

Notices

COBRA Continuation of Medical Coverage Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees and/or dependents may be able to continue their enrollment in certain medical plans such as health and dental, if such coverage is terminated or changed due to a qualifying event.

Medicare Part D Creditable Coverage

The City's prescription drug coverage(s) is considered Creditable Coverage under Medicare Part D. If you or your dependents are or will be eligible for Medicare, you may obtain more information by requesting a Medicare Part D Disclosure of Creditable Coverage Notice.

More information is available on the above notices by contacting Human Resources.

Group Insurance Eligibility

The City's group insurance plan year is October 1st through September 30th.

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are full time employees working a minimum of 30 hours per week. Coverage will be effective the 1st of the month following 30 days of employment. For example: If you are hired on April 11th, your coverage will be effective on June 1st.

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

Dependent Eligibility

A dependent is defined as the legal spouse (a person to whom the participant is legally married) and/or dependent child(ren) of the participant or the spouse. Dependent children may be covered through the end of the calendar year in which the child reaches age 26 for medical. The term "child" includes any of the following:

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

Dependent Eligibility Age Requirements

Eligibility requirements for eligible Over-age Dependents have been eliminated for group medical insurance. Over-age Dependents may be covered by the medical plans through the end of the calendar year in which the child turns age 26.

Medical coverage may continue to the end of the calendar year in which the dependent reaches the age of 30, if the dependent is:

- 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 handicapped.

Disabled Dependents

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

1. The dependent is physically or mentally disabled and incapable of self-sustaining employment; AND
2. The dependent is otherwise eligible for coverage under the group medical plan; AND
3. The dependent has been continuously insured; AND
4. Coverage began prior to the age of 19.

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

Taxable Dependents

Employees covering adult children under their health insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, imputed income for the value of the applicable adult child's coverage for the coverage period must be reported on the employee's W-2. Imputed income is the dollar value of insurance coverage attributable to covering the adult child. There is no imputed income if an adult child is eligible to be claimed as a dependent for federal income tax purposes on the employees tax return. Check with Human Resources for further details if you are covering an adult child who will turn 27 any time in the upcoming calendar year or for more information.

Qualifying Events and IRS Code Section 125

IRS Code Section 125

Premiums for medical, dental, vision insurance, and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, if the event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Examples of Qualifying Events

- You get married or divorced
- You have a child, gain legal custody or adopt a child
- Your spouse and/or other dependent(s) die(s)
- You, your spouse, or dependent(s) terminate or start employment
- An increase or decrease in your work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Gain or loss of Medicare coverage
- Gain or loss of eligibility for Medicaid or CHIP coverage (60 day notification period)

IMPORTANT

If you experience a qualifying event, **you must contact Human Resources within 30 days of the qualifying event** to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied and the employee may be responsible both legally and financially for any claim and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place on the first of the month following the qualifying event, except for newborns which are effective on the date of birth. Any cancellations will be processed at the end of the month, except coverage terminates the date following a death. You will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Health Insurance: Consumer Driven Health Plan (CDHP)

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

Tel-Drug Prescription & Mail-Order Program
Customer Service: (800) 835-3784
www.teldrug.com

The City offers a health insurance plan through CIGNA. A brief description of the Consumer Driven Health Plan (CDHP) is provided below. A summary of benefits is provided on the following page. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact CIGNA's Customer Service.

The Premium Rates will be provided in a separate handout.

In-Network Benefits

The CDHP Plan is an "open access" plan that provides benefits for services received in or out of network. Providers who contract with insurance companies agree to accept discounted rates and are referred to as "participating" or "in network." Once the in network deductible is satisfied, you will pay the coinsurance, which is a percentage of the discounted amount. An in-network provider cannot charge you more than the agreed upon discounted amount for covered services. The network of participating providers that the plan utilizes is the **Open Access Plus Network**. To view the network, log on to **www.cigna.com**, click "Provider Directory," and enter the information for the provider and the network name and click on "Start Search."

Out-of-Network Benefits

Providers who do not contract with insurance carriers because they do not accept their discounted rates are referred to "non-participating" or "out-of-network." Understanding how your insurance company pays for out-of-network services is important because you will usually pay more.

The insurance company processes charges based on what it determines the "Usual, Customary and Reasonable (UCR)" charge is for a specific service. UCR or the "allowed amount" can be defined as the most common charge for a particular medical procedure performed in a specific geographic area. Since there is no contract in place between the insurance company and out-of-network provider, the provider may charge an amount higher than UCR. The difference between the UCR amount and the provider's higher charge is called "balance billing," **and is in addition to your deductible and coinsurance responsibility.**

Plan Year Deductible

The CDHP first requires you to satisfy a Plan Year Deductible (PYD) before benefits begin. All family members contribute towards the "Employee + 1" or "Employee + Family" deductible. The plan will not pay an individual's claims until the total "Employee + 1"or "Employee + Family" deductible has been met, even if he or she has met the individual deductible. However, the deductible is waived and coverage is provided at 100% for preventative services (see your enrollment materials for a listing of preventative services). Once your deductible is satisfied, the plan then pays 80% of all eligible charges up to the out-of pocket maximum.

Plan Year Out-of-Pocket Maximum

Once the out-of-pocket maximum is met, the plan will then provide 100% of coverage thereafter for that individual or family for the remainder of the plan year. Out-of-pocket maximums include deductibles and coinsurance. All family members contribute towards the "Employee + 1"or "Employee + Family" out-of-pocket maximum. The plan cannot pay an individual's covered expenses at 100% until the total "Employee + 1"or "Employee + Family" out-of-pocket maximum has been reached.

Health Reimbursement Account (HRA)

The City contributes tax-free dollars to an HRA on your behalf. The money in your account automatically pays the first portion of your deductible. Any money left in the account will carry over to the next plan year until the out-of-pocket maximum is reached. If you contribute to a Health Care Flexible Spending Account, your HRA pays first, then the FSA.

Auto Enrollment

In accordance with the Patient Protection and Affordable Care Act, **all new full-time benefit-eligible employees shall be automatically enrolled in the individual coverage benefits option, unless you elect to decline or choose a different plan option**. You are responsible for notifying Human Resources of your desire not to enroll in the group health plan and for completing all required paperwork in order to decline coverage.

Health Insurance: Consumer Driven Health Plan (CDHP) At-A-Glance

Network	Open Access Plus Network	
HRA Funding (City Contribution)	**In Network**	**Out of Network***
Employee	$750	
Employee + 1	$1,250	
Employee + Family	$1,500	
Plan Year Deductible (PYD)	**In Network**	**Out of Network***
Employee	$1,500	$3,000
Employee + 1	$2,250	$4,500
Employee + Family	$3,000	$6,000
Coinsurance	**In Network**	**Out of Network***
Member Responsibility	20%	50%
Plan Year Out-of-Pocket Maximum	**In Network**	**Out of Network***
Employee	$3,000	$6,000
Employee + 1	$4,500	$9,000
Employee + Family	$6,000	$12,000
What Applies to the Out-of-Pocket Maximum	Deductibles and Coinsurance	
Physician Services	**In Network**	**Out of Network***
Physician Office Visit	20% After PYD	50% After PYD
Specialist Office Visit		
Diagnostic Services	**In Network**	**Out of Network***
Clinical Lab (Blood Work) at Independent Facility	20% After PYD	50% After PYD
X-rays at Independent Facility		
Advanced Imaging (MRI, PET, CT)		
Hospital Services	**In Network**	**Out of Network***
Inpatient	20% After PYD	50% After PYD
Outpatient		50% After PYD
Physician Services at Hospital		50% After PYD
Emergency Room		20% After PYD
Urgent Care Facility		20% After PYD
Mental Health / Alcohol & Substance Abuse	**In Network**	**Out of Network***
Inpatient and/or Outpatient	20% After PYD	50% After PYD
Prescription Drugs (Rx)	**In Network**	**Out of Network**
Generic	30% After PYD	Not Covered
Preferred Brand Name	40% After PYD	
Non-Preferred Brand Name	50% After PYD	
Mail Order Drug (90 Day Supply)	Included	

mycigna.com

mycigna.com is the 24-hour secure member self-service website and provides access to many self-service choices and health related information. Log on to myCIGNA.com for personalized services including:

- Verify your personal information
- Review your coverage
- Search "Frequently Asked Questions"
- Find network providers
- Download forms
- View your claims
- Learn about discount programs
- Communicate with Customer Service
- Quicken health expense tracker

24 Hour Help Information Hotline (800) CIGNA-24

The CIGNA 24-Hour Health Information Line provides you 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 your child has a fever in the middle of the night? Have you injured yourself and are not sure if you should seek treatment or go see a doctor? 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 health conditions to help you weigh the risks and advantages of treatment options. The call is FREE and is strictly confidential.

Healthy Rewards

CIGNA's Healthy Rewards is provided to you automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to www.mycigna.com and select Healthy Rewards to learn more about these programs or call 1-800-870-3470.

- Vision Care
- Lasik Vision Correction Services
- Fitness Club Discounts
- Nutrition Discounts
- Hearing Care
- Tobacco Cessation
- Alternative Medicine

Perscription Drug Coverage & Mail Order Program

The CDHP provides coverage for prescription drugs after the deductible is met. However, the CDHP offers a prescription discount plan during this period. The plan provides coverage for prescription drugs. In addition, you can participate in the Rx Mail Order Program for maintenance medications for conditions such as allergies, asthma, birth control, diabetes, high blood pressure, glaucoma and many more. This program offers a prescription discount plan and your prescription drugs are conveniently delivered directly to your home. Additional information, including claim forms and mailing envelopes for the prescription mail order program, may be obtained by contacting Tel-drug at 1-800-835-3784 or on-line at www.teldrug.com.

Dental Insurance: PPO Plan

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

The City offers a dental PPO Plan through CIGNA. A brief description of the dental PPO Plan is provided below, and the employee costs per pay period are shown on the premium table to the right. A summary of benefits is provided on the following page. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact CIGNA's Customer Service.

2011/2012 PPO Dental Insurance Plan
Bi-weekly Pay Period Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + Spouse	$12.12
Employee + Child(ren)	$18.64
Employee + Family	$34.03

In-Network Benefits

The dental PPO plan is "open access" and allows you to receive services from any dental provider without selecting a Primary Dental Provider (PDP) and does not require referrals to specialists. The network of participating dental providers the plan utilizes is the **Radius Dental Network**. The PPO plan provides benefits for services received from in-network and out-of-network providers. You are responsible for a Plan Year Deductible (PYD) and then coinsurance based on the plan's Usual, Customary and Reasonable (UCR) charge limitations. To search for a participating provider, call Customer Service or go to www.cigna.com, select "Provider Directory", complete the search criteria and select "Radius" for the plan then hit "Start Search."

Out-of-Network Benefits

Providers who do not contract with insurance carriers because they do not accept their discounted rates are referred to as "non-participating" or "out of network." Understanding how your insurance company pays for out-of-network services is important because you will usually pay more.

The insurance company processes charges based on what it determines the "Usual, Customary and Reasonable (UCR)" charge is for a specific service. UCR or the "allowed amount" can be defined as the most common charge for a particular dental or medical procedure performed in a specific geographic area. Since there is no contract in place between the insurance company and out-of-network provider, the dentist may charge an amount higher than UCR. The difference between the UCR amount and the dentist's higher charge is called "balance billing." **Balance billing is in addition to your deductible and coinsurance responsibility**.

Plan Year Deductible

There is a Plan Year Deductible (PYD) that needs to be met on this plan for basic and major services. This plan's benefits begin once each covered member satisfies the deductible. The deductible is applied collectively for either in-network or out-of-network services. Once any 3 covered members in a family each satisfies the deductible, the deductible will then be considered met for all covered members in that family. Once you satisfy your annual deductible, your coinsurance responsibility will be based on the plan's in-network discounted fee schedule or UCR for out-of-network and will be determined by the type of services you receive as summarized in the table on the following page.

Coinsurance

The percentage of coinsurance a covered member is responsible for is based upon the plan's discounted fee assigned to each particular service. For example, in Class II services (Basic Restorative Care), the plan pays 80% coinsurance for out-of-network services and the member is responsible for 20% coinsurance, once the annual deductible has been satisfied. Please note: Out-of-network providers may also "balance bill."

Plan Year Benefit Maximum

The maximum benefit the dental plan will pay for each covered member is $1,500 for in-network and out-of-network services per Plan Year.

Dental Insurance: PPO Plan At-A-Glance

Network	Radius Dental Network	
Plan Year Deductible	**In-and Out-of-Network Combined**	
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Plan Year Benefit Maximum	**In-and Out-of-Network Combined**	
Per Member	$1,500	
Class I Services: Diagnostic & Preventative	**In Network**	**Out of Network***
Routine Oral Exam	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings		
Complete X-rays (Every 3 Years)		
Bitewing X-rays		
Class II Services: Basic Restorative	**In Network**	**Out of Network***
Fillings	Plan Pays: 80%	Plan Pays: 80% *(Subject to Balance Billing)*
Deep Cleaning (1 Per Lifetime)		
Simple Extractions		
Root Canal Therapy		
Periodontal Services		
Oral Surgery		
General Anesthesia		
Class III Services: Major Restorative**	**In Network**	**Out of Network***
Crowns	Plan Pays: 50%	Plan Pays: 50% *(Subject to Balance Billing)*
Bridges		
Dentures		
Class IV Services: Orthodontia**	**In Network**	**Out of Network***
Lifetime Maximum	$1,500	
Benefit	50% Coinsurance After Plan Deductible	

***Out-Of-Network Balance Billing**

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

****Late Entrant Limitations will apply.**

Vision Insurance: EyeMed Vision Insurance Plan

EyeMed
Customer Service: (866) 723-0513
www.eyemedvisioncare.com

The City offers a vision plan through EyeMed. A brief description of the EyeMed Vision Insurance Plan is provided below, and the employee costs per pay period are shown on the premium table to the right. A summary of benefits is provided on the following page. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact EyeMed's Customer Service.

2011/2012 EyeMed Vision Insurance Plan
Bi-weekly Pay Period Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	$2.50
Employee + 1 Dependent	$4.74
Employee + Family	$6.96

In-Network Benefits

The vision plan offers you and your covered dependents with coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered members can select any network provider that 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 your appointment.

Out-of-Network Benefits

You may also choose to receive services from vision providers that do not participate in the vision network. If so, you would be covered up to the dollar amount listed for the applicable benefit and the rest would be paid out of pocket. At the time of service, routine vision examination services and basic optical needs will be covered as shown on the following summary.

If you go out of network you would be required to make payment at the time of your appointment. EyeMed will then reimburse you based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

How to Locate a Provider

To search for a participating provider, call Customer Service or go to www.eyemedvisioncare.com. Choose "Locate a Provider" and enter your zip code, then click "Submit."

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 per calendar year.

Vision Insurance: EyeMed Vision Insurance Plan At-A-Glance

Services	**In Network**	**Out of Network**
Eye Exam	$10 Copay	Up to $15
Materials	$20 Copay	Plan Reimburses Member Based on the Type of Service
Frequency of Services	**In Network**	**Out of Network**
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses	**In Network**	**Out of Network**
Single	Paid in Full After Copay	Up to $8 Reimbursement
Bifocal		Up to $18 Reimbursement
Trifocal		Up to $35 Reimbursement
Frames	**In Network**	**Out of Network**
Reimbursement	$120 Retail Allowance 20% Discount Above $120	Up to $60 Reimbursement
Contact Lenses*	**In Network**	**Out of Network**
Fitting, Follow-up & Lenses	$105 Allowance	Up to $84 Reimbursement
Lasik	**In Network**	**Out of Network**
Discount Programs	15% off retail price OR 5% off promotional pricing	In Network Only

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

Flexible Spending Accounts

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

Claims: PO Box 182223
Chattanooga, TN 37422-7223
Claims Fax: (423) 553-8953

The City offers Flexible Spending Accounts (FSAs) administered through CIGNA.

If you have predictable medical expenses for yourself or your family, such as deductibles and copays, or any work-related day care expenses, FSAs may be right for you. FSAs allow you to set aside money for reimbursement of medical and day care expenses you regularly pay. The amount you set aside is not taxed and is automatically deducted from your paycheck and deposited into the FSA. During the year, you have access to this account for reimbursement of some expenses that are not covered by insurance. An FSA not only results in a substantial tax savings, it also increases your spending power. There are two types of FSAs:

Health Care Reimbursement Account	Dependent Care Reimbursement Account
This account allows you to set aside up to an **annual maximum of $5,000.** This money will not be taxable income to you and can be used to offset the cost of a wide variety of eligible expenses that generate out-of-pocket costs for you or your qualified dependents. Employees 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. ***NOTE: The entire Health Care FSA election is available to you on the first day coverage is effective.**	This account allows you to set aside up to an **annual maximum of $2,500 ($1,250 if you file a separate tax return)** for work-related day care expenses. Qualified expenses include adult and child day care centers, preschool, and before/after school care for eligible children and adults. Please note that if your family's annual income is over $20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your dependent must be: • a child under the age of 13, or • a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household. ***NOTE: Unlike the Health Care FSA, you will only be reimbursed up to the amount that has been deducted from your paycheck for Dependent Care expenses.**

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

- Ambulance service
- Chiropractic care
- Dental fees/Orthodontic fees
- Diagnostic tests/Health screenings
- Doctor fees
- Drug addiction/Alcoholism treatment
- Experimental medical treatment
- Eyeglasses/Contact lenses (corrective)
- Hearing aids and exams
- Injections & vaccinations
- Lasik surgery
- Mental healthcare
- Nursing services
- Optometrist fees
- Physician office visits
- Prescription drugs
- Wheelchairs
- X-rays

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

Flexible Spending Accounts

FSA Guidelines

- **Any unused funds after a plan year ends and all claims have been filed cannot be returned to you nor carried forward to the next plan year.**
- You may enroll in either or both FSAs during open enrollment period or new hire eligibility only.
- You cannot transfer money between FSAs
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You may not be reimbursed for a service which you have not received.
- You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- You have a grace period at the end of the plan year to claim reimbursement (until December 15th) for eligible expenses incurred during your period of coverage (October 1, 2011 to September 30, 2012).

Here's How It Works

Employee earning $30,000 elects to place $1,000 into their FSA Health Care Savings Account, with payroll deductions being $38.46 based on a 26 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

	With the Plan	Without the Plan
Salary	$30,000	$30,000
FSA Contribution	- $1,000	- $0
Taxable pay	$29,000	$30,000
Estimated Tax (22.65% = 15% + 7.65 FICA	- $6,568	- $6,795
After Tax Expenses	- $0	- $1,000
Spendable Income	$22,432	$22,205
Tax Savings	**$227**	

NOTE: Be conservative when estimating your medical and/or dependent care expenses. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and all claims have been filed can not be returned to you nor carried forward to the next plan year. This is known as the "USE IT OR LOSE IT" rule.

Filing a Claim

To file a claim, you must submit your completed claim form and include a copy of the receipt as proof of the expense. Once completed, you may submit your claim either by mail or fax. The IRS requires FSA participants to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

Flexible Spending Accounts

Planning Your Health Care FSA Elections

When considering your Health Care FSA election amount, you need to first understand what your insurance plans will pay. The FSA will not reimburse you for expenses paid by insurance.

The worksheet on the right may help you estimate your annual contributions to cover certain medical expenses for yourself and any dependents. You may want to talk to your doctor, dentist, or other providers as well as your qualified dependents to help you estimate your expenses.

The entire Health Care FSA election amount balance is available on the first day of the plan year; however, if the entire balance is used, your Health Care FSA contribution per pay period will still remain the same.

Planning Your Dependent Care FSA Elections

Dependent Care FSA expenses are somewhat more predictable. You figure out what you spend on a per paycheck basis for preschool, after-school or care for older dependents that is necessary for you to work. If you are married, the same applies for both you and your spouse to work.

The day care can be provided in a licensed day care center or by an individual in your home or the day care provider's home. Day camps are also eligible if the services are used in lieu of regular day care.

The other major difference between a Health Care FSA and a Dependent Care FSA is that you may obtain reimbursement for dependent care expenses only up to the amount you have contributed. If you have contributed $100 and you request $150 in reimbursements for eligible expenses, you will only receive $100 until future contributions are received (in the same plan year).

Health Care FSA Worksheet	
Deductible	
Copays	
Coinsurance	
Eyeglasses/Contact Lenses	
Dental Care/Orthodontia	
Prescription Drugs	
Surgery	
Other	
This is the amount to consider contributing to the Health Care FSA	
Divide by the Number of Pay Periods	÷ by 26
Health Care FSA Contribution Per Pay Period	

Dependent Care FSA Worksheet	
Child Day Care Expenses	
Preschool Expenses	
Summer Day Camp Expenses	
Adult Day Care Expenses	
Other	
This is the amount to consider contributing to the Dependent Care FSA	
Divide by the Number of Pay Periods	÷ by 26
Health Care FSA Contribution Per Pay Period	

Basic and AD&D Life Insurance

Aetna
Customer Service: (800) 523-5065
www.aetna.com

Claim Fax : (800) 238-6239
Portability Customer Service: (800) 826-7448

Basic Term Life

At no cost to the employee, the City will provide Basic Term Life insurance for all eligible employees through Aetna. All full time employees working a minimum of 20 hours per week are covered for a benefit amount as follows:

- **Class I: General Employees** — 2x your basic annual earnings (BAE), with a $10,000 minimum and a $300,000 maximum rounded to the next higher $1,000.
- **Class II: Police/Fire Employees** — 1x your basic annual earnings (BAE), with a $10,000 minimum and a $225,000 maximum rounded to the next higher $1,000.

Accidental Death & Dismemberment

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

Life Insurance Imputed Income

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

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

Voluntary Life and AD&D Insurance

Aetna
Customer Service: (800) 523-5065
www.aetna.com

Claim Fax : (800) 238-6239
Portability Customer Service: (800) 826-7448

Voluntary Employee Life Insurance

Eligible employees may elect to purchase additional life insurance on a voluntary basis through Aetna. This coverage may be purchased in addition to the Basic Term Life coverage. Voluntary Life Insurance offers coverage for yourself, spouse or child(ren) at different benefit levels. Premiums for this coverage will be made via post tax payroll deduction.

- **Option 1:** 1x your basic annual earnings (BAE), with a $10,000 minimum and a $200,000 maximum rounded to the next higher $1,000.
- **Option 2:** 2x your basic annual earnings (BAE), with a $10,000 minimum and a $350,000 maximum rounded to the next higher $1,000.
- Benefit amounts are subject to the following age reduction schedule:
  50% at age 72
- Check BenTek for Rate Calculations.

Voluntary Life and AD&D Insurance *(continued)*

Voluntary Spouse and/or Dependent Child(ren) Life Insurance

- Spouse — $10,000
- Unmarried child, age 14 days to age 25 — $5,000
- Coverage cannot exceed 50% of the employee's voluntary coverage amount
- Dependent Life Insurance is $0.99 bi-weekly

Voluntary AD&D Insurance

Eligible employees may elect to purchase additional Accidental Death & Dismemberment (AD&D) insurance on a voluntary basis through Aetna. This coverage may be purchased in addition to the Basic AD&D. Premiums for this coverage will be made via post tax payroll deduction.

- **Option 1:** 1x your basic annual earnings (BAE), with a $10,000 minimum and a $200,000 maximum rounded to the next higher $1,000.
- **Option 2:** 2x your basic annual earnings (BAE), with a $10,000 minimum and a $350,000 maximum rounded to the next higher $1,000.
- Benefit amounts are subject to the following age reduction schedule:
  50% at age 72
- Check BenTek for Rate Calculations.

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

Long Term Disability

Aetna
Customer Service: (800) 523-5065
www.aetna.com

The City offers Long Term Disability (LTD) to all eligible full-time employees (excluding Police and Fire) at no cost through Aetna. The LTD pays you a percentage of your weekly earnings if you become disabled due to an illness or accident.

LTD Plan Summary

- The LTD program offers a benefit of 60% of your monthly earnings, subject to a maximum of $6,000 per month.
- An employee must be disabled for 90 days prior to becoming eligible for benefits.

Employee Assistance Plan (EAP)

Horizon Health
24-Hour Crisis Line: (800) 272-7252
www.horizoncarelink.com
Username: CON
Password: CON

Provided by the City at no cost to you, a comprehensive Employee Assistance Program (EAP) is available to you and each member of your family through Horizon Health. Horizon Health offers access to licensed mental health professionals through a confidential program that is protected by state and federal laws. The EAP program is available to help you gain a better understanding of problems that affect you, locate the best professional help for your particular problem, and decide upon a plan of action. All EAP counselors are professionally trained and are certified and licensed in their fields. Master-level counselors are available 24 hours a day, 7 days a week.

What is an Employee Assistance Program?

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

- Anxiety
- Legal and financial concerns
- Depression
- Life improvement
- Family and/or marriage problems
- Stress
- Grief and bereavement
- Substance abuse
- Legal & financial consultation

What is Horizon Health?

The City recognizes that employees' personal responsibilities may, at times, spill over into the workplace. To help ensure employees are able to address these concerns with minimal disruption, the program provides employees and their family members assistance for a variety of concerns – including child care, elder care, daily-living issues, and other issues they may encounter.

Are your services confidential?

Yes. Receipt of EAP services is 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 will not, however, receive specific information regarding the referred employee's case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Retirement Plans

ICMA
Tony Chifari, Retirement Specialist
Toll Free: (866) 886-8025
www.achifari@icmarc.org

AIG / VALIC
Ryan Austin, Financial Advisor
Local: (239) 292-7433
www.ryan.austin@aigretirement.com

Nationwide
Ron LeClair, Plan Representative
Local: (239) 594-8931
www.LeClair@nationwide.com

401(g) Defined Contribution Plan

Benefit eligible employees are eligible to contribute three percent (3%) of their gross pay into a 401(g) Defined Contribution Plan which will be matched by an additional two percent (2%) provided by the City. Eligible employees may enroll after they have completed their initial probation or during the Open Enrollment period.

457(b) Deferred Compensation Plan

The tax advantages, plus plan features and benefits, make the 457 (b) Deferred Compensation Plan an ideal way to help accumulate funds for your retirement. Employees determine their investment allocations(s) among many accounts available and maintain control through allocation changes and transfer options within the vendors system.

The City has three (3) Defined/Deferred Contribution vendors:

- ICMA
- AIG / Valic
- Nationwide

Please contact Human Resources for additional information.

Notes

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

Notes

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GEHRING GROUP

11505 Fairchild Gardens Ave., Suite 202
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696; Fax: (561) 626-6970
www.gehringgroup.com

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