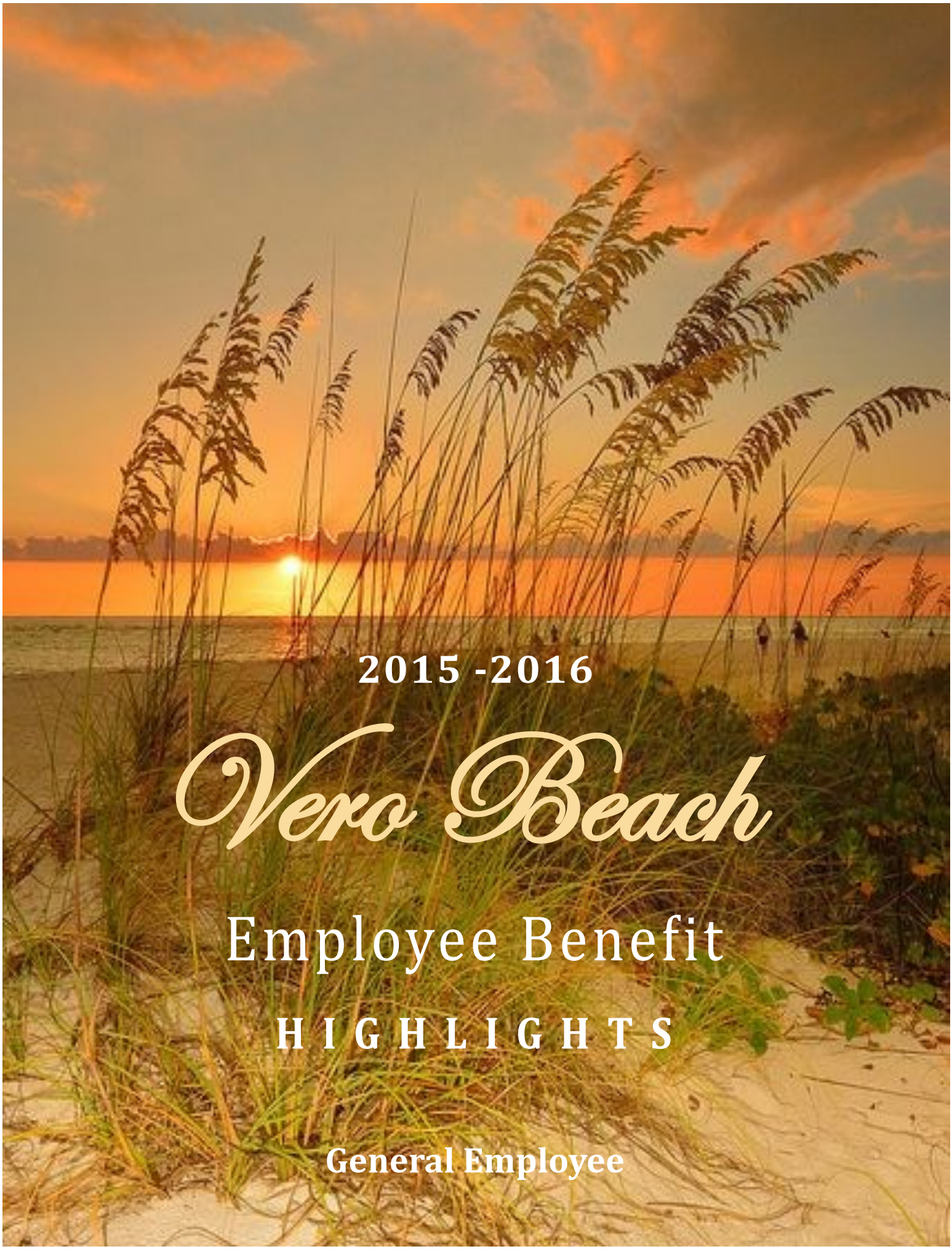


2015 -2016

Vero Beach

Employee Benefit

H I G H L I G H T S

General Employee

Important Contact Information

	Contact Name	Contact Information
City of Vero Beach - Risk Management	Kathy Taube, Benefits Administrator	(772) 978-4923 Fax: (772) 978-4925 E-mail: ktaube@covb.org
City of Vero Beach - Human Resources	Human Resources	(772) 978-4900 Fax: (772) 978-4915
Service Providers	**Contact Name**	**Contact Information**
Health Insurance	United Health Care	Customer Service: (866) 633-2446 or the number on the back of ID Card www.myuhc.com
Trustmark Voluntary Benefit Programs (Critical Illness, Accident, Universal Life with Long Term Care)	Explain My Benefits, Inc.	(888) 734-6937 www.trustmarksolutions.com
Group Term Life Insurance	Symetra	Customer Service: (800) 426-7784 www.symetra.com
Long Term Disability Insurance	Symetra	Customer Service: (800) 426-7784 www.symetra.com
Dental Insurance	Florida Combined Life	Customer Service: (888) 223-4892 www.floridabluedental.com
Vision Insurance	20/20 EyeCare Plan	Customer Service: (800) 525-9778 Fax: (954) 917-2962 www.2020eyecareplan.com
Legal Services/Identity Theft	Preferred Legal Plan	Customer Service: (888) 577-3476 www.preferredlegal.com
Flexible Spending Accounts/COBRA	Eagles Benefits by Design	Customer Service: (800) 726-5603 Fax: (772) 334-7059 www.mytakecareplan.com
Employee Assistance Program	Corporate Care Works	24-Hour Careline: (800) 327-9757 Fax: (904) 296-1511 www.corporatecareworks.com
401a, 457 & Roth IRA Retirement Plans	ICMA Torri L. Chronnister	Customer Service: (800) 669-7400 Fax: (202) 962-4601 www.icmarc.org

All benefits covered in this booklet are subject to change. This is an Employee Benefit Highlight Summary and not a contract. If you have any benefit questions, please contact Risk Management.

Table of Contents

Introduction

The City of Vero Beach offers a comprehensive fringe benefit package for all eligible employees. A variety of these employee benefit programs have been highlighted in this booklet as a general reference. Please refer to the City's Handbook and group insurance Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. Questions and further clarifications regarding this booklet's contents may be directed to Risk Management.

The City of Vero Beach is a drug-free workplace, in accordance with FS 112.0455; Drug Free Workplace Act; Florida Department of Transportation's Rule 49, Part 40; CFR Title 49, Parts 382, 392, and 395; and Florida Statute for Workers' Compensation 440.102.

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 Risk Management.

Benefit Eligibility

Employee Eligibility

For employees eligible to participate in the City's group insurance plans highlighted in this booklet, coverage will be effective the first day of the month following completion of one full calendar month of employment. Example: If you are hired on January 11th, your coverage will be effective on March 1st. If you terminate employment with the City, your insurance will continue through the end of the month in which you terminate.

Dependent Eligibility

A dependent is defined as the legal spouse 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 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant of the participant's spouse

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

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 Risk Management if further clarification is required.

WELCOME TO ENROLLMENT FOR YOUR 2016 BENEFITS!

The City of Vero Beach offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

You can find more detailed information about your benefits and how to enroll at your Benefit Enrollment Portal:

www.explainmybenefits.biz/vero-beach

Enrollment Process!

1. All benefit eligible employees are required to complete the enrollment process whether you are electing benefits or waiving all benefits in order to confirm your choices.

2. This year we have moved to an online enrollment process. This new technology, **EMB Enroll**, will enable a more efficient process to communicate and administer the benefits to our insurance carriers. Employees will self-enroll online and the system will guide you through the benefit offerings.

3. Please be prepared to complete your enrollment with all your demographic and dependent information. You will be verifying all this information that will be in the system so it is accurate when sent to all the insurance carriers.

Helpful Reminders: What You Will Need to Enroll

DEPENDENT INFORMATION

If you intend to elect ANY benefit for your spouse and/or eligible dependents they must be listed as dependents in the system and you MUST have their SSN so they can be input into the system. You will not be able to proceed with your enrollment and confirm your elections without inputting the SSN's for your spouse and/or dependents. Spouse, Children, and Family coverage levels will not be available for you to select if the dependent information is not present.

Health Insurance

If you are electing coverage for the first time and have had other health insurance coverage for the past 18 months, please bring a copy of detailed information including name of insurance company, contact number, the type of insurance (HMO, PPO, etc.) and dates of coverage. If you have had no insurance for the past 62 days or more, you will not need to bring this information.

If you intend to insure eligible dependents, please bring each dependent's social security number, birth certificate, marriage license (if applicable) and detailed information reflecting health insurance coverage each dependent has had during the past 18 months (see above).

Term Life Insurance

The information required for each beneficiary you designate includes their name, social security number, address and relationship to you.

When Can I Enroll?

New hire initial enrollment and annual open enrollment allows for employees of the City to enroll or make changes in any of the plans without a qualifying event. In order to make changes outside of your enrollment period, there would need to be a qualifying event such as the birth of a child, change in marital status, death, or loss of coverage due to no fault of your own. An enrollment application must be submitted to the insurance carrier via the Benefits Administrator's office within thirty-one (31) days of the qualifying event in order for coverage to be effective.

Contact Risk Management for the necessary forms. Proof of the qualifying event will be required.

IRS Code Section 125 and Qualifying Events

IRS Code Section 125

Premiums for medical, dental, vision, certain supplemental plans 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 include the following:

- 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 Risk Management at (772) 978-4923 within 30 days of the qualifying event to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied and you may be responsible both legally and financially for any claim and/or expense incurred as a result of you 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. You will be required to complete a Benefits Change Form & furnish valid documentation supporting a change in status or qualifying event.

Health Insurance General Information

Coverage when Traveling

When traveling within the United States, you are covered under your health insurance whether you need care in urban or rural areas. Outside of the United States, you have access to doctors and hospitals in more than 200 territories around the world through United Healthcare. Visit www.myuhc.com to access the Doctor and Hospital Finder or call UHC at 1-866-633-2446 for the names and addresses of doctors and hospitals in the area where you or a covered dependent need care.

Prescription Drug Coverage & Prescription Mail Order Program through OptumRx

All health insurance plan options provide coverage for prescriptions through OptumRx. In addition, if you are on a maintenance medication, you have the opportunity to maximize your savings by participating in OptumRx's prescription drug mail order program. The mail order program allows you to receive a three month's supply of a maintenance medication at home at a cost of only two and a half co-pays. You save a month's copay and are provided the convenience of having your medications delivered directly to your home. Additional information including applications and mailing envelopes for the prescription mail order program may be obtained by contacting OptumRx at 1-855-505-8107 or visiting www.optumrx.com and logging in.

Health Insurance: Plan 1 - United Health Care Low Plan FX4

United Health Care Choice Plus Plan
Customer Service: (866) 633-2446 or the number on the back of ID Card
www.myuhc.com

Health Insurance - Per Pay Period Payroll Deduction

Tier of Coverage	Total Premium Per Month	City Portion Per Month	Employee Portion Per Month	Payroll Deduction Per Pay Period
Employee Only	$581.38	$581.38	$0	$0
Employee + Spouse	$1,286.52	$964.88	$321.64	$160.82
Employee + Child	$1,161.68	$871.26	$290.42	$145.21
Employee + Family	$1,827.68	$1,370.76	$456.92	$228.46

The City offers two health insurance plans through United Health Care. A brief description of the UHC Choice Plus Plan FX4 is provided below, and the employee costs per pay period are shown on the premium table above. 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 UHC Customer Service.

In-Network Benefits

The UHC Choice Plus Plan FX4 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 either "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, by contract, cannot charge you more than the agreed upon discounted amount for covered services. The network of participating providers that the plan utilizes is the **Choice Plus Network**. To determine if your doctor is in the Choice Plus network, log on to **www.myuhc.com**, click "Find Physician, Laboratory or Facility," choose United Healthcare Choice Plus from the list and enter the information for the provider for which you are searching.

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 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." **Balance billing is in addition to your deductible and coinsurance responsibility**.

Calendar Year Deductible

There is a $500 individual and $1,000 family in-network and a $1,000 individual and $2,000 family out-of-network Calendar Year Deductible (CYD) that must be met for certain services before plan benefits begin. (Typically, the CYD is applicable where you see that coinsurance is required).

Calendar Year Out-of-Pocket Maximum

Once any covered member incurs charges of $3,000 for an individual and/or $6,000 for a family in network, and $6,000 for an individual and/or $12,000 for a family out of network, the plan will then provide 100% coverage thereafter for that individual or family, for the remainder of the calendar year. Charges that are applied to the Out-of-Pocket Maximum include coinsurance and annual deductible (excludes Rx). Fees for non-covered services and fees over the plan's allowable amount are excluded from the Calendar Year Out-of-Pocket Maximum.

Health Insurance: Plan 1 - Choice Plus Plan FX4 Low Plan At-A-Glance

Network	Choice Plus Plan FX4	
Calendar Year Deductible (CYD)	**In Network**	**Out of Network***
Single	$500	$1,000
Family	$1,000	$2,000
Coinsurance	**In Network**	**Out of Network***
Member Responsibility	20%	30%
Out-of-Pocket Maximum	**In Network**	**Out of Network***
Single	$3,000	$6,000
Family	$6,000	$12,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Co-pays and Coinsurance *(includes Rx)*	
Physician Services	**In Network**	**Out of Network***
Physician Office Visit	$20	30% After CYD
Specialist Office Visit	$40	
Diagnostic Services (Freestanding Facility)	**In Network**	**Out of Network***
Clinical Lab (Blood Work) at Independent Facility	$0	30% After CYD
X-rays at Independent Facility	$0	
Advanced Imaging (MRI, PET, CT)	20% after CYD	
Hospital Services	**In Network**	**Out of Network***
Inpatient	20% After CYD	30% After CYD
Outpatient Surgery		
Physician Services at Hospital	20% After CYD	
Emergency Room	$125	
Urgent Care Center	$35	30% After CYD
Mental Health / Alcohol & Substance Abuse	**In Network**	**Out of Network***
Inpatient	20% After CYD	30% After CYD
Outpatient	$40	30% After CYD
Prescription Drugs (Rx)	**In Network**	**Out of Network***
Generic	$10	UHC Discount
Preferred Brand Name	$30	UHC Discount
Non-Preferred Brand Name	$50	UHC Discount
Mail Order Drug (90 Day Supply)	$25/$75/$125 (2.5x Co-pay)	UHC Discount

***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.

Health Insurance: Plan 2 - United Health Care Mid Plan FXW

United Health Care Choice Plus Plan
Customer Service: (866) 633-2446 or the number on the back of ID Card
www.myuhc.com

Health Insurance - Per Pay Period Payroll Deduction

Tier of Coverage	Total Premium Per Month	City Portion Per Month	Employee Portion Per Month	Payroll Deduction Per Pay Period
Employee Only	$608.18	$581.38	$26.80	$13.40
Employee + Spouse	$1,345.86	$964.88	$380.98	$190.49
Employee + Child	$1,215.26	$871.26	$344.00	$172.00
Employee + Family	$1,911.98	$1,370.76	$541.22	$270.61

The City offers two health insurance plans through United Health Care. A brief description of the UHC Choice Plus Plan FXW is provided below, and the employee costs per pay period are shown on the premium table above. 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 UHC Customer Service.

In-Network Benefits

The UHC Choice Plus Plan FXW 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 either "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, by contract, cannot charge you more than the agreed upon discounted amount for covered services. The network of participating providers that the plan utilizes is the **Choice Plus Network**. To determine if your doctor is in the Choice Plus network, log on to **www.myuhc.com,** click "Find Physician, Laboratory or Facility," choose United Healthcare Choice Plus from the list and enter the information for the provider for which you are searching.

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 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." **Balance billing is in addition to your deductible and coinsurance responsibility**.

Calendar Year Deductible

There is a $500 individual and $1,000 family in-network and a $1,000 individual and $2,000 family out-of-network Calendar Year Deductible (CYD) that must be met for certain services before plan benefits begin. (Typically, the CYD is applicable where you see that coinsurance is required).

Calendar Year Out-of-Pocket Maximum

Once any covered member incurs charges of $2,500 for an individual and/or $5,000 for a family in network, and $5,000 for an individual and/or $10,000 for a family out of network, the plan will then provide 100% coverage thereafter for that individual or family, for the remainder of the calendar year. Charges that are applied to the Out-of-Pocket Maximum include coinsurance and annual deductible (excludes Rx). Fees for non-covered services and fees over the plan's allowable amount are excluded from the Calendar Year Out-of-Pocket Maximum.

Health Insurance: Plan 2 - Choice Plus Plan FXW Mid Plan At-A-Glance

Network	Choice Plus Plan FXW	
Calendar Year Deductible (CYD)	**In Network**	**Out of Network***
Single	$500	$1,000
Family	$1,000	$2,000
Coinsurance	**In Network**	**Out of Network***
Member Responsibility	10% After CYD	30% After CYD
Out-of-Pocket Maximum	**In Network**	**Out of Network***
Single	$2,500	$5,000
Family	$5,000	$10,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Co-pays and Coinsurance *(includes Rx)*	
Physician Services	**In Network**	**Out of Network***
Physician Office Visit	$15	30% After CYD
Specialist Office Visit	$30	
Diagnostic Services (Freestanding Facility)	**In Network**	**Out of Network***
Clinical Lab (Blood Work) at Independent Facility	$0	30% After CYD
X-rays at Independent Facility	$0	
Advanced Imaging (MRI, PET, CT)	10% After CYD	
Hospital Services	**In Network**	**Out of Network***
Inpatient	10% After CYD	30% After CYD
Outpatient Surgery	10% After CYD	
Physician Services at Hospital	10% After CYD	
Emergency Room (Waived if Admitted)	$125	
Urgent Care	$35	30% After CYD
Mental Health / Alcohol & Substance Abuse	**In Network**	**Out of Network***
Inpatient	10% After CYD	30% After CYD
Outpatient	$30	
Prescription Drugs (Rx)	**In Network**	**Out of Network***
Generic	$10	UHC Discount
Preferred Brand Name	$30	UHC Discount
Non-Preferred Brand Name	$50	UHC Discount
Mail Order Drug (90 Day Supply)	$25/$75/$125 (2.5x Co-pay)	UHC Discount

***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.

Trustmark Personalized Voluntary Benefit Program

What are Voluntary Benefits?

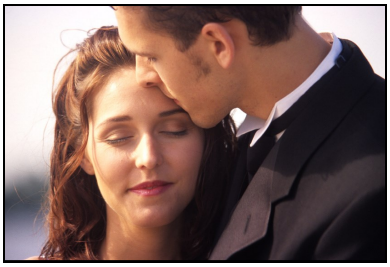
These benefits are designed to strengthen your overall benefits package. You can customize your benefits based on your need and affordability. **You are eligible to participate in these benefits even if you do not participate in the city sponsored medical plan.**

- **OWNERSHIP** - You own the policies and they are 100% portable - at the same benefit level and the same price
- **SPECIAL UNDERWRITING - ONE TIME ONLY OFFER - Guaranteed Issue at Initial Offering**
- Voluntary Benefits are designed to provide additional cash flow to employees to help with expenses after a sickness or injury
  Such as: Out-of-pocket medical expenses, house, car and food bills
- These cash benefits are paid to you and your family above and beyond and completely separate from your medical insurance and any other benefits
- These cash benefits are paid directly to you - not to a hospital or to a doctor
- These benefits can cost as little as a few dollars per week
- Benefits are conveniently payroll deducted

Trustmark Critical Illness/Cancer Plan

To file a claim: http://trustmarksolutions.com/file-claim/

The Critical Illness/Cancer Plan is a benefit that will pay you a lump sum of money if you are diagnosed with a critical illness, heart attack, internal cancer or stroke. The cash benefit is provided upon the first diagnosis of a covered condition to help you with associated costs and beyond.



Underwriting: **Guaranteed Issue offering for Newly Benefit Eligible Employees ONLY.**
$10,000 employee / $5,000 spouse / $1,000 children

Regardless of other coverage in force, the benefit is paid out in a full lump sum.

Examples of covered conditions:
Invasive Cancer, Heart Attack, Stroke, Renal (Kidney Failure), Blindness, ALS (Lou Gehrig's Disease), Major Organ Transplant, Paralysis of Two or More Limbs, Coronary Artery Bypass Surgery (25% benefit), Carcinoma In Situ (25% benefit)

A Health Screening Benefit is included in your Critical Illness/Cancer Policy and Trustmark pays up to $100 for each insured. Each covered person will get one immunization or one screening test per calendar year. (60 day waiting period for this benefit)

Examples of health screenings:

- Low dose mammography
- Pap smear
- Serum cholesterol
- Prostate specific antigen
- Stress test
- Colonoscopy
- Bone marrow
- Chest X-ray

Also included is a Double Benefit Option that provides a second cash payment in the event a covered person is diagnosed with a different condition or illness. Pays an additional 100% of the original benefit.

Rates
This benefit is customized by each employee so rates vary, but can start as little as a few dollars a week.

Trustmark Accident Plan

To file a claim: http://trustmarksolutions.com/file-claim/

A plan that helps pay for the unexpected expenses that result from an accident

- **On and off the job coverage** = 24 hours per day, 7 days a week
- Benefits are paid regardless of any other coverage
- Cash benefits are paid directly to you
- Family coverage available
- Sports related injuries covered as well

Just a few examples of benefits included in the plan:

- Emergency Room Visits - $150
- Hospitalization - $3,200 admission benefit, $500 per day benefit
- Fractures - up to $15,000
- Dislocations - up to $12,000
- Wellness Benefit - $100 per person (2x per year)
- See brochure for a complete list of benefits

The Wellness Benefit provides a benefit when you have a standard screening test performed. A Wellness Benefit is paid for all routine physicals, vaccines, and health screening tests for each covered person. (60 day waiting period for the benefit)

2 per person/annually = $200 annually per insured

Examples of screening tests:

- Mammography
- Pap smear
- Serum cholesterol
- PSA test for prostate cancer
- Stress test on bicycle or treadmill
- Colonoscopy
- Chest X-ray
- Fasting blood glucose test

The amount paid out each time is $100 - so each family member can receive up to $200 each year. If you take the annual cost of the plan and subtract the total cash benefit you and your family receive back for wellness visits you can essentially get the plan for free.

Deduction Per Pay Period

Employee	$9.24
Employee & Spouse	$14.15
Employee & Child(ren)	$21.50
Family	$26.41

Life Insurance

Trustmark Universal LifeEvents® with Long Term Care

To file a claim: http://trustmarksolutions.com/file-claim/

Universal LifeEvents® with Long Term Care includes both a death benefit and a living benefit.

- Trustmark Universal LifeEvents® with Long Term Care is a permanent life insurance that is designed to match your needs throughout your lifetime. It pays a higher death benefit during your working years when expenses are high and you need maximum protection.
- The Universal LifeEvents® with Long Term Care is priced to remain the same cost to you until age 100.
- The death benefit reduces at age 70 when the need for life insurance typically decreases.
- The Living Benefit, Long Term Care never reduces and is 4% of the original death benefit per month for up to 25 months.
- **If you use the Long Term Care benefit, your death benefit amount does not reduce due to the Benefit Restoration feature included.**
- Coverage availabe for spouse and children as well.

Underwriting: **Guaranteed Issue offering for Newly Benefit Eligible Employees ONLY.**

The lesser of the face amount purchased by $10 per week or $200,000

LifeEvents® with Long Term Care example: $100,000 Death Benefit

	Maximum Benefit Amount	
Long Term Care Benefit (LTC): Pays a monthly benefit equal to 4% of your death benefit for up to 25 months.	Before Age 70 **$100,000**	After Age 70 **$100,000**
Benefit Restoration: Restores the death benefit that is reduced to pay for LTC.	**$100,000**	**$33,333**
Total Maximum Benefit: Long Term Care Benefits may double the value of your insurance	**$200,000**	**$133,333**

Rates

This benefit is customized by each employee so rates vary, but can start as little as a few dollars a week.

Symetra Term Life

Customer Service: (800) 426-7784

www.symetra.com

Basic Term Life and Accidental Death & Dismemberment

The City provides Basic Life insurance through Symetra Life Insurance Company for all eligible employees at no cost to the employee. The Basic Life insurance benefit equals one times your January compensation rounded up to the next highest $1,000 (up to a maximum of $150,000). Example: If your January salary is $24,003.50, the Life insurance benefit is rounded to $25,000. The City also provides Accidental Death & Dismemberment (AD&D) insurance which pays in addition to the Basic benefit when loss occurs as a result of an accident.

Supplemental Term Life Insurance

City employees may elect to purchase Additional Life Insurance on a voluntary basis through Symetra Life Insurance Company via payroll deduction. Additional Life Insurance may be purchased to cover yourself at the benefit levels described below and the premium rate calculation can be obtained from Risk Management.

- You may select additional, employee-paid life insurance equal to 1 or 2 times your January salary to a maximum of $300,000.
- Up to $150,000 of coverage is guaranteed, no medical questionnaire needed (new hires only).
- Coverage reduces to half at age 70.

You may elect to purchase a voluntary $20,000 Term Life policy at the time of retirement (policy reduces to half at age 70).

Long Term Disability Insurance

Symetra

Customer Service: (800) 426-7784
www.symetra.com

Base Plan

The City provides Long Term Disability (LTD) insurance through Symetra Life Insurance Company for all eligible employees at no cost to the employee. The LTD benefit pays you a percentage of your gross monthly earnings if you become disabled due to injury or sickness. A summary of the plan's benefits is provided below. *This benefit is reduced by deductible income such as retirement and Social Security.*

- The LTD benefit pays 60% of your monthly earnings up to a monthly maximum of $5,000.
- The LTD benefit begins paying on the 181st day of a disability.
- If you return to work on a part-time basis, you may continue to be eligible for partial benefits.
- Periodic evaluations will occur at the discretion of Symetra.
- The employee will continue to receive benefits for 24 months if they are unable to return to their "own occupation." Partial disability during this time is covered if the employee is unable to earn 80% of pre-disability earnings in his /her own occupation.
- Safety employees have a 12 month "own occupation" period (see explanation above).
- After 24 months (12 months for Safety employees), if the employee can return to any occupation in which they are suitably trained, educated, and capable of performing, the employee must return to that occupation. Partial disability during this time is covered if the employee is unable to earn 50% of pre-disability earnings in any occupation.

Enhanced Plan

City employees may elect to purchase an Enhanced LTD insurance plan through Symetra Life Insurance Company on a voluntary basis via payroll deduction.

Although both plans provide similar coverage, the Enhanced Plan's LTD benefits:

- Are payable on the 91st day of a disability (compared to the 181st day with the Base Plan).
- Include a Transitional Duty Package and a Reasonable Accommodation Expense Benefit for workplace modifications required after expediting a disability.

Rates for the Enhanced LTD Plan are based on your monthly gross earnings. Rate schedules may be obtained from Risk Management.

Dental Insurance: FCL BlueDental Choice Plus Low Option PPO Plan

Florida Combined Life
Customer Service: (888) 223-4892
www.floridabluedental.com

The City offers two dental insurance plans through Florida Combined Life. A brief description of the FCL BlueDental Choice Plus Low Option 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 Florida Combined Life Dental Customer Service.

Dental Insurance - Per Pay Period Payroll Deduction

Tier of Coverage	Low Option Plan
Employee	$11.74
Employee + Spouse	$24.23
Employee + Child(ren)	$32.82
Employee + Family	$51.38

In-Network Benefits

The FCL BlueDental Choice Plus Low Option 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 **PPO Network**. To determine if your doctor is in the network or to find a network provider, log on to www.floridabluedental.com and click "Find a Dentist". 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.

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 $25 individual and $75 family in-network and a $50 individual and $150 family out-of-network plan year deductible. The deductible must be met before benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit the dental plan will pay for each covered member is $1,000 for in- and out-of-network services combined. There is also a $1,000 lifetime maximum for orthodontia.

BlueDental Maximum Rollover

With BlueDental Maximum Rollover, each year when you visit a dentist and use less than the annual threshold amount allowed, you receive Maximum Rollover (MR) dollars to help cover future unexpected visits or higher out-of-pocket costs for complex procedures. Your MR account can keep growing year after year and is applied automatically as long as you:
1) receive at least one covered service during the plan year, 2) are an active member of the plan on the last day of the plan year, and 3) don't exceed the claim payment threshold in your plan year.

Benefit Threshold	$1000	Dental benefits received for the year cannot exceed this amount.
Maximum Annual Carryover Amount	$350	Amount added to the following year's benefit maximum (in-network only)
Maximum Accumulated Carryover	$1,000	Maximum possible accumulation for benefit rollover.

Dental Insurance: FCL BlueDental Choice Plus Low Plan At-A-Glance

Network	FCL BlueDental Choice Plus Low Option	
Calendar Year Deductible (CYD)	**In Network**	**Out of Network**
Per Member	$25	$50
Per Family	$75	$150
Waived for Class I Services	Yes	
Calendar Year Benefit Maximum	**In Network**	**Out of Network***
Per Member	$1,000	
Class I Services: Diagnostic & Preventative	**In Network**	**Out of Network***
Routine Oral Exam	100%	100% *(Subject to Balance Billing)*
Routine Cleanings		
Bitewing X-rays		
Class II Services: Basic Restorative	**In Network**	**Out of Network***
Complete X-rays	60%	60% *(Subject to Balance Billing)*
Fillings		
Extractions - Routine and Surgical		
Deep Cleaning		
Endodontics (Root Canal Therapy)		
Periodontics		
Oral Surgery		
General Anesthesia/Intravenous Sedation *(limitations apply)*		
Class III Services: Major Restorative	**In Network**	**Out of Network***
Crowns	25%	25% *(Subject to Balance Billing)*
Dentures		
Bridges		
Class IV Services: Orthodontia	**In Network**	**Out of Network***
Lifetime Maximum	$1,000	
Benefit *(Age limit: 19)*	50%	50% *(Subject to Balance Billing)*

Please note the following:

- *Each covered family member is entitled to 2 FREE cleanings per calendar year covered under the preventative benefit (once every 6 months).*

***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.

Dental Insurance: FCL BlueDental Choice High Option PPO Plan

Florida Combined Life
Customer Service: (888) 223-4892
www.floridabluedental.com

The City offers two dental insurance plans through Florida Combined Life. A brief description of the FCL BlueDental Choice High Option 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 Florida Combined Life Dental Customer Service

Dental Insurance - Per Pay Period Payroll Deduction

Tier of Coverage	High Option Plan
Employee	$18.91
Employee + Spouse	$39.04
Employee + Child(ren)	$43.99
Employee + Family	$71.38

In-Network Benefits

The FCL BlueDental Choice High Option 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 **PPO Network**. To determine if your doctor is in the network or to find a network provider, log on to www.floridabluedental.com, click "Find a Dentist". 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.

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 $25 individual and $75 family in-network and a $50 individual and $150 family out-of-network plan year deductible. The deductible must be met before benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit the dental plan will pay for each covered member is $1,000 for in- and out-of-network services combined. There is also a $1,000 lifetime maximum for orthodontia.

BlueDental Maximum Rollover

With BlueDental Maximum Rollover, each year when you visit a dentist and use less than the annual threshold amount allowed, you receive Maximum Rollover (MR) dollars to help cover future unexpected visits or higher out-of-pocket costs for complex procedures. Your MR account can keep growing year after year and is applied automatically as long as you:
1) receive at least one covered service during the plan year, 2) are an active member of the plan on the last day of the plan year, and 3) don't exceed the claim payment threshold in your plan year.

Benefit Threshold	$1000	Dental benefits received for the year cannot exceed this amount.
Maximum Annual Carryover Amount	$350	Amount added to the following year's benefit maximum. (in-network only)
Maximum Accumulated Carryover	$1,000	Maximum possible accumulation for benefit rollover.

Dental Insurance: FCL BlueDental Choice High Plan At-A-Glance

Network	FCL BlueDental Choice High Option	
Calendar Year Deductible (CYD)	**In Network**	**Out of Network**
Per Member	$25	$50
Per Family	$75	$150
Waived for Class I Services	Yes	
Calendar Year Benefit Maximum	**In Network**	**Out of Network***
Per Member	$1,000	
Class I Services: Diagnostic & Preventative	**In Network**	**Out of Network***
Routine Oral Exam	100%	100% *(Subject to Balance Billing)*
Routine Cleanings		
Bitewing X-rays		
Class II Services: Basic Restorative	**In Network**	**Out of Network***
Complete X-rays	80%	80% *(Subject to Balance Billing)*
Fillings		
Simple Extractions		
Deep Cleaning		
Endodontics (Root Canal Therapy)		
Periodontics		
Oral Surgery		
General Anesthesia/Intravenous Sedation *(limitations apply)*		
Class III Services: Major Restorative	**In Network**	**Out of Network***
Crowns	50%	50% *(Subject to Balance Billing)*
Dentures		
Bridges		
Class IV Services: Orthodontia	**In Network**	**Out of Network***
Lifetime Maximum	$1,000	
Benefit *(Age limit: 19)*	50%	50% *(Subject to Balance Billing)*

Please note the following:

- *Each covered family member is entitled to 2 FREE cleanings per calendar year covered under the preventative benefit (once every 6 months).*

***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.

Vision Insurance: 20/20 EyeCare Plan

20/20 EyeCare Plan
Customer Service: (800) 525-9778
www.2020eyecareplan.com

The City offers vision insurance through 20/20 EyeCare Plan. A brief description of the 20/20 EyeCare 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 exclusions and stipulations please refer to the carrier's benefit summary or contact 20/20 EyeCare Customer Service

Vision Insurance
Per Pay Period Payroll Deduction

Tier of Coverage	Employee Cost
Employee	$2.88
Employee + 1 Dependent	$5.19
Employee + 2 or More Dependents	$8.55

In-Network Benefits

The vision plan offers you and your covered dependents coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. Vision exams and lenses are covered once every 12 months and frames may be replaced every 12 months. At the time of service routine vision exams and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic service upgrades will additional if chosen at the time of your appointment.

Out-of-Network Benefits

Covered members 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. If you receive services from an out-of-network provider, you pay the provider's regular charges at the time you receive your services, submit a claim and the vision plan will reimburse you according to the plan's non-network benefit schedule.

How to Locate a Provider

To search for a participating provider, call Customer Service (800) 535-9778 or go to www.2020eyecareplan.com, choose "Vision Provider Network," then fill in your criteria.

Calendar Year Deductible

There is no Calendar Year Deductible.

Calendar Year Benefit Maximum

There is no Out-of-Pocket Maximum. However, there are benefit reimbursement maximums for certain services per calendar year.

Vision Insurance: 20/20 EyeCare Plan At-A-Glance

Services	**In Network**	**Emergency/Out of Network**
Eye Exam	$4 Copay	Covered Up To $35
Frequency of Services	**In Network**	**Out of Network**
Examination	1 Every 12 Months	
Lenses		
Frames	1 Frame Every 12 Months	
Lenses	**In Network**	**Out of Network**
Single	$10 Copay	Covered Up To $25
Bifocal		Covered Up To $40
Trifocal		Covered Up To $60
Frames	**In Network**	**Out of Network**
Reimbursement	$85 Retail Allowance after $10 Copay	Covered Up To $45
Contact Lenses*	**In Network**	**Out of Network**
Fitting, Follow-up & Lenses	$119 Allowance after $4 Copay	$85 Allowance
Lasik	**In Network**	**Out of Network**
Discount Programs	Discount Available Through 20/20 EyeCare Plan	

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

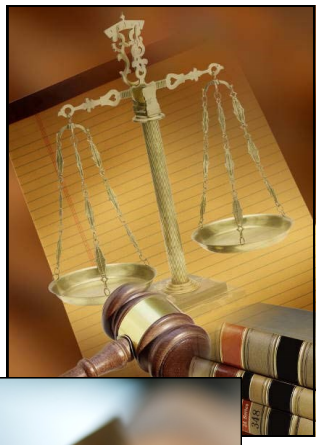
Vero Beach Providers *				
Desrosiers, Joyce O.D 632 21st Street Vero Beach, FL 32960 (772) 567-6513	Lavoie, William O.D. 530 21st Street Vero Beach, FL 32963 (772) 562-2020	Fleming, Daniel O.D. 1960 25th Avenue, Suite 102 Vero Beach, FL 32960 (772) 567-5102	Roselli, Brice O.D. 333 17th Street Vero Beach, FL 32960 (772) 978-0845	Weiss, Benjamin O.D. 6200 20th Street, Room 330 Vero Beach, FL 32966 (772) 564-2070

** A complete list of providers is available on the 20/20 website at www.2020eyecareplan.com*

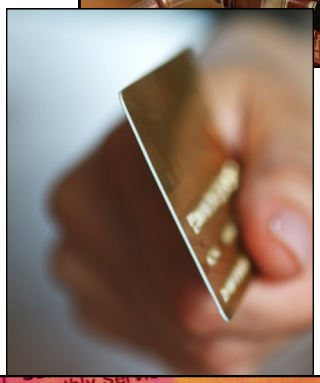
Legal Insurance and Identity Theft Protection

Preferred Legal Plan
Customer Service: (888) 577-3476
www.preferredlegal.com

City employees may elect to purchase Legal Insurance through the Preferred Legal Plan on a voluntary basis through payroll deduction. Legal Insurance may be purchased to cover yourself, your spouse and/or your children.



The Preferred Legal Plan is a licensed legal expense organization providing its members with full service and representation on all types of legal services, including **divorce, traffic tickets, buying or selling a home, bankruptcy, wills, probate, DUI, immigration, credit report issues, child support, custody and visitation, garnishments, loan modifications, foreclosures, criminal defense, litigation, small claims court, personal injury, landlord-tenant disputes domestic violence and more.**



- *Free* unlimited Legal advice via phone consultation
- *Free* face-to-face consultations with attorneys
- *Free* review of legal documents (real estate contracts, lease agreements, etc.)
- *Free* letters and phone calls to third parties on your behalf
- *Free* credit report analysis and repair and settling accounts in collection
- *Free* Identity Theft information and restoration
- *Free* simple Wills for member and spouse (or domestic partner)
- *Free* legal forms available through PLP Form Library
- *Free* notary services
- *40%-70% reduced legal fees* for attorney representation on all types of legal services
- *24 hours a day, 7 days a week* access with *access to PLP's statewide panel* of quality attorneys located throughout Florida
- *Spouse, dependent children and entire household are covered* for one low price.
- *Tri-lingual attorneys.* Se habla espanol. Nou pale Creol.
- *Unlimited, immediate use of membership.* All pre-existing issues covered.
- *No long-term contracts.* You may cancel at any time. Membership is portable.

New - ProtectMyID® Elite by Experian

- Early warning Surveillance Alert - notifications sent to members via text or e-mail on new activity related to their identities through daily monitoring, and monthly "All Clear" email notifications.
- Daily 3-Bureau Credit report monitoring tracks 50 leading indicators of identity theft.
- Internet scan—Monitors online sources where personal data is sold.
- Lost Wallet protection.
- checking new credit cards, loans inquiries, and more on member's credit report
- $1,000,000 Identity Theft Insurance to cover items like illegal EFT Transfers, lost wages, legal fees, private investigator costs.
- Identity Theft Resolution Agents to help resolve potential identity theft from start to finish.

Per Pay Period Payroll Deductions

Preferred Legal Plan Only	$4.98
Preferred Legal Plan with ProtectMyID® - Employee	$8.48
Preferred Legal Plan with ProtectMyID® - Employee & Spouse	$11.98
ProtectMyID® Only - Employee	$4.50
ProtectMyID® Only - Employee & Spouse	$9.00

Flexible Spending Accounts

Eagles Benefits By Design
Customer Service: (800) 726-5603
Claims Fax: (772) 334-7059
www.mytakecareplan.com

The City offers Flexible Spending Accounts (FSAs) administered through Eagles Benefits By Design

If you have predictable medical expenses for yourself or your family, such as deductibles and co-pays, 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:

Medical Flexible Spending Account	Dependent Care Flexible Spending Account
This account allows you to set aside up to an **annual maximum of $2,550.** This money will not be taxable income to you and can be used to off-set 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 $2,550** 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 • 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

Note: Effective 1/1/2011 over-the-counter items are no longer a qualified expense, unless prescribed by a physician and can only be reimbursed when a valid physician's prescription is submitted with your claim to Eagles Benefits by Design. 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

- **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 can 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 cannot be reimbursed for a service which you have not received.
- You cannot 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 (until December 15th) to claim reimbursement for eligible expenses incurred during your period of coverage within the plan year (October 1st - September 30th).
- Domestic Partners are not eligible as federal law does not recognize them as a qualified dependent.

Here's How It Works

An employee earning $30,000 elects to place $1,000 into their FSA Health Care Savings Account, with payroll deductions being $41.66 based on a 24 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.

Debit Card

FSA participants can request a debit card for payment of eligible expenses. Employees must call Eagles Benefits by Design at (800) 726-5603 or go online to the Eagles Benefits by Design web site, www.mytakecareplan.com, to request a card. Participants are able to pay for most qualified services and products 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.

Employee Assistance Program

Corporate Care Works
24-Hour Careline: (800) 327-9757
Fax: (904) 296-1511
www.corporatecareworks.com

The City provides an Employee Assistance Program (EAP) through Corporate Care Works for all employees and their immediate family members at no cost to the employee. The EAP offers confidential, short-term professional counseling on a 24-hour-a-day basis, including referrals to community resources. The EAP provides assistance on a variety of topics as summarized below.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employees and their family members 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:

- Stress
- Marital
- Emotional
- Family
- Health
- Financial
- Legal
- Job-related
- Alcohol / Drugs

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.

Additional Programs Included with Your Health Insurance

www.MyUCH.com

Myuhc.com is United Health Care's member self-service website. Log on to *myuhc.com,* click on *Register Now* and follow the step-by-step instructions. This website provides you with 24-hour access to many self-service choices and other health related information. Examples of available services members can receive by logging on to www.myuhc.com include:

- Verify your personal information
- Review your coverage
- View your claims
- Request Information
- Download forms
- Search frequently asked questions
- Find a provider
- Learn about BCBS discount programs such as vision, hearing, etc.

Care24

Looking for answers to general health and prevention questions? Interested in education for significant medical issues? Searching for understandable, evidence-based information on available treatment options? Members can log on to www.myuhc.com to obtain health and wellness related information and support through:

- Health Coaches — Speak privately with experienced, licensed health care professionals, including registered nurses, dieticians and respiratory therapists, 24 hours a day, 7 days a week.
- Web-based information tools, operated and maintained by Health Dialog with over 27,000 pages of up-to-date, easy to understand, in-depth information on more than 1,900 clinical topics including medical tests and medications.
- Free audio, video and printed information on specific health conditions to help you weigh the risks and advantages of treatment options.

UnitedHealth Allies

(800) 860-8773
www.unitedhealthallies.com

- Vision care, glasses, and contact lenses
- Hearing care and aids
- Fitness club memberships, exercise footwear and apparel
- Weight loss management
- Alternative medicine
- Elder care advisory services
- Hotel rooms and travel information

For more information, please contact UnitedHealth Allies at (800) 860-8773 or visit www.unitedhealthallies.com and select "Create Account" (you will need your UHC ID card) to get started.

Retirement Savings Plans

457 Deferred Compensation

All full-time employees are eligible to join the International City Management Association's (ICMA) 457 Deferred Compensation Plan upon hire. This deferred compensation plan is strictly governed by the Internal Revenue Service (IRS) including withdrawals made prior to termination of employment. Participants may make their own decisions regarding fund choices. The ICMA representative visits the City regularly to answer any specific questions. A summary of the plan is provided below.

Contributions:	Minimum contribution is $10. All contributions must be made in whole dollar amounts; percentages will not be accepted. The maximum contribution is $18,000 per calendar year. Participants age 50 and over may contribute an additional $6,000 for a total contribution of $24,000. All contributions must be made through payroll deductions; no over-the-counter contributions will be accepted. Social Security will be deducted from earnings, including the deferred compensation portion.
Contribution Changes:	Changes in the amount of deferral may be made at any time during the year. Upon receipt of the appropriate form in the Human Resources Department, every effort will be made to change the contribution on the next payroll unless a specific date is requested.
Transfers:	Transfers from one fund to another may be made by using the automated telephone service (transfer will be made at the end of the business day), or by using the Internet.
Withdrawals:	Emergency withdrawals are governed by the IRS. The City allows employees to apply for loans under the 457 program for specific reasons in accordance with IRS regulations. New laws affecting the 457 allow terminated employees a wide variety of options in withdrawing this money or rolling over the funds to another pre-tax plan.

Roth IRAs

The City offers Roth IRAs through ICMA. Roth IRAs are funded with after-tax dollars; deductions from your payroll are taken after taxes have been calculated. If you are 59-1/2 years old and have held an IRA account for at least 5 years, your earnings may be withdrawn tax free. The maximum contribution that can be made to your Roth IRA is $5,500 per year and participants age 50 and over may contribute an additional $1,000 for a total of $6,500. Consolidating other Roth IRAs by transfers or rollovers is permitted. Please see the ICMA Roth IRA brochure for further plan details.

Filing Status	Modified Adjustment Gross Income (MAGI)	Allowable Contribution To Roth IRA
Single:	Up to $116,000	Full amount.
	$116,001 - $131,000	Partial Amount.
	Over $131,000	No contribution allowed.
Married / Joint:	Up to $183,000	Full amount.
	$183,001 - $193,000	Partial Amount.
	Over $193,000	No contribution allowed.

Holidays

The City observes the holidays listed below. To be eligible for holiday pay, employees must work or be on a "paid" leave the scheduled work day before and after the holiday. (Shift workers should speak to their supervisor regarding rules for shift workers. See the Personnel Rules for details).

- New Year's Day
- Martin Luther King, Jr. Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day
- The day after Thanksgiving
- Christmas Eve
- Christmas Day

Paid Leaves

Annual Leave

Employees accrue annual leave each pay period (excluding the first pay of the year) as provided in the accrual table to the right. *(Please refer to the Police Union Contract, Teamster Contract, or Personnel Rules governing usage and accruals).*

Department heads, charter officers and other professionals designated by the City Manager will earn annual leave at the rate of either 75 or 80 hours for the first year of employment, either 150 or 160 hours per year in years 2 through 5 inclusive, and either 187.5 or 200 hours per year thereafter, depending on bi-weekly work schedule.

Continuous Employment	75 Hour Employees	80 Hour Employees
Number of Years	Annual Hours Earned	Annual Hours Earned
1 - 5 Years	75 Hours	80 Hours
6 - 10 Years	112.5 Hours	120 Hours
11 Years	120 Hours	128 Hours
12 Years	127.5 Hours	136 Hours
13 Years	135 Hours	144 Hours
14 Years	142.5 Hours	152 Hours
15 Years	150 Hours	160 Hours
16 Years	157.5 Hours	168 Hours
17 Years	165 Hours	176 Hours
18 Years	172.5 Hours	184 Hours
19 Years	180 Hours	192 Hours
20 Years	187.5 Hours	200 Hours

Medical Leave

- Employees accrue medical leave at the rate of one day per month. This accrual is credited the first pay of each month.
- Employees are expected to use these accrued hours prudently.
- Medical leave may be used during the employee's probationary period.
- Employees may use either 75 or 80 hours of their accrued sick leave to care for a member of their immediate family.

Bereavement Leave

Employees are allowed 3 working days with pay for a death in the immediate family. An additional 3 days can be granted under unusual circumstances.

Court Leave

Employees will be paid their normal wages when called for jury duty during their normal working hours. Employees acting as witnesses on behalf of the City or a qualifying agency are paid their normal salary.

City Programs

Other Programs

As a City employee, you may also take advantage of:

- Direct deposit of City payroll checks
- Participation in the City's Wellness Programs

Federal Programs

Basic Family and Medical Leave Act Entitlement (FMLA)

The purpose of the Basic Family and Medical Leave Act (FMLA) is to provide up to twelve (12) weeks of job-protected leave to eligible employees for certain family and personal medical reasons. Basic FMLA leave shall be granted and required for any of the following reasons:

- For incapacity due to pregnancy, prenatal medical care or childbirth.
- To care for the employee's child following birth or adoption, or placement of a child into the employee's foster care.
- To care for the employee's spouse, child or parent who has a serious health condition.
- For a serious health condition that makes you, the employee, unable to perform the essential functions of the job.

Military Family Exigency Leave Entitlement

The purpose of the Military Family Exigency Leave Entitlement is to provide twelve (12) weeks of job protected leave to eligible employees with a spouse, son, daughter or parent on active duty or call to active duty status in the National Guard or Reserves for:

- Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.
- Qualifying exigencies include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

Military Caregiver Entitlement

The purpose of the special leave entitlement is to permit eligible employees to take up to twenty-six (26) weeks of leave during a single twelve (12) month period as follows:

- To care for the employee's spouse, son, daughter, parent or next of kin if he/she is a service member who is currently a member of the Armed Forces, National Guard or Reserves with a serious injury or illness incurred in the line of active duty that renders him/her medically unfit to perform his or her duties. The service member must be undergoing medical treatment, recuperation, or therapy, or be in outpatient status, or on the temporary disability retired list.
- In the event the covered service member has no spouse, son, daughter or parent, the next of kin is their nearest blood relative in the following order of priority: blood relatives who have been granted legal custody of the covered service member, brothers and sisters, grandparents, aunts and uncles, and first cousins. Employees will be required to furnish proof that they are the service member's next of kin.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

An employee, spouse of an employee or a dependent child of an employee covered by the City's group health plan has the right to choose this continuation coverage if coverage is lost for any of the reasons provided below.

Employee:	1) Reduction in hours of employment (that disqualifies group insurance participation eligibility); or 2) Termination of employment (for reasons other than gross misconduct).
Spouse of an Employee:	1) The death of your spouse; or 2) A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment; or 3) Divorce or legal separation from your spouse; or 4) Your spouse becomes entitled to Medicare.
Dependent Child of an Employee:	1) The death of a parent; or 2) A termination of the parent's employment (for reasons other than gross misconduct) or a reduction in the parent's hours of employment with the City; or 3) Parent's divorce or legal separation; or 4) A parent becomes entitled to Medicare; or 5) The dependent child ceases to be a "dependent child" under the City's group health plan.

Under the law, the employee or a family member has the responsibility to inform the City group health plan's Group Administrator of a divorce, legal separation, or a child losing dependent status under the City of Vero Beach group health plan within 30 days of the date of the event or the date in which coverage would end under the plan because of the event, whichever is later. The City of Vero Beach has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction of hours of employment or Medicare entitlement.

NOTES

Visit the City's Employee Access website for forms and additional information.
To reach this website, go to www.covb.org and click the
Employee Access button at the bottom of the page, left hand side.
For username & password, contact Risk Management.

Risk Management
(772) 978-4920

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