PALM BEACH
Gardens

2025-2026 | EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

Human Resources Department	Brooke Judkins Human Resources Manager	(561) 799-4215	bjudkins@pbgfl.gov
Medical Insurance	Florida Blue - Group No. 91062	(800) 352-2583	www.floridablue.com
Prescription Drug Coverage	Prime Therapeutics	(877) 794-3574	www.myprime.com
Mail Order Pharmacy Program	Amazon Pharmacy	(855) 965-7539	www.amazon.com
Self Administered Specialty Rx	Accredo	(844) 516-3319	
Injectables Rx	CVS Caremark Specialty	(844) 278-5108	
Durable Medical Equipment	Carecentrix	(877) 561-9910	
Teladoc	Florida Blue	(800) 835-2362	www.teladochealth.com
Health Savings Account	Health Equity	(877) 924-3967	www.healthequity.com
Dental Insurance	Humana - Group No. 839405	(800) 233-4013	www.humana.com
Vision Insurance	Superior Vision - Group No. 31782	(800) 507-3800	www.superiorvision.com
Flexible Spending Accounts	HealthEquity	(877) 924-3967	www.healthequity.com
Employee Assistance Program	Aetna Resources for Living	(888) 238-6232	www.resourcesforliving.com
Basic Life and AD&D Insurance	Ochs/Securian	(800) 392-7295	www.securian.com
Voluntary Life Insurance	Ochs/Securian	(800) 392-7295	www.securian.com
Long Term Disability Insurance	Ochs/Madison National Life	(800) 392-7295	www.madisonlife.com
Health and Wellness Center	Premise Health	(561) 775-8242	members.premisehealth.com/palm-beach-gardens
Retirement	Florida Retirement System (FRS)	(844) 377-1888	www.myfrs.com
	MissionSquare Retirement - Steve Feigelis	(202) 759-7058	sfeigelis@missionsq.org
Supplemental Benefits	Aflac - Kim Sahoy	(786) 340-1640	Kimberly_Sahoy@us.aflac.com
Claims, Billing & Benefit Assistance	Risk Strategies	(800) 244-3696	pbg@risk-strategies.com

Table of Contents

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

Introduction

The City of Palm Beach Gardens provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the City's Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact the Human Resources Department.

Notification of Grandfather Status

The City of Palm Beach Gardens has determined the medical plan offered is a "grandfathered medical plan" under the Patient Protection and Affordable Care Act (the ACA). As permitted by the ACA, grandfathered medical plans can preserve certain basic medical coverage that was in effect when the law was enacted. Being a grandfathered medical plan means an employer's plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive medical services without any cost sharing. However, grandfathered medical plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply, which protections do not apply to grandfathered medical plan and what might cause a plan to change from grandfathered medical plan status can be directed to the Human Resources Department. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

IMPORTANT NOTES

The Consolidated Appropriations Act, 2021 included the requirement of the No Surprises Act which took effect on January 1, 2022 for health care providers, facilities, and health plans. The No Surprises Act was designed to protect patients from surprise medical bills for situations such as emergency care or out-of-network provider charges at in-network facilities. It is important to note that if a patient wishes to obtain services from out-of-network providers or facilities and acknowledges receipt of the information, the patient is knowingly waiving the protections of the law. Ground Ambulance services may not be covered as in-network.

Online Benefit Enrollment

The City provides employees with an online benefits enrollment platform through Employee Self Services (ESS). The ESS is available 24 hours a day during the annual Open Enrollment Period to select or change insurance benefits. Employees can access the ESS outside of open enrollment to view paycheck history, tax withholdings, w-2 elections, direct deposit information and more. .

To Access the Employee Self Services

- ✓ From any computer, log on to **www.pbgfl.gov**
- ✓ Registered users sign in by entering your username and password
- ✓ Once logged on, Select "Benefits Enrollment" from the drop down
- ✓ Click on "Go to Enrollment Form"
- ✓ Read legal disclaimer, click "I accept" then click "continue"
- ✓ Read instructions given
- ✓ Current elections are listed on the description tab. Decline means not enrolled in the plan. To enroll, click the action link labeled "change"
- ✓ Save selections after each change

Accuracy of Enrollee Information

In order to maintain the City's overall health plan costs, it is important that only individuals eligible for benefits are actually enrolled. This help keeps costs down for active employees, the City and retirees who pay the full cost of benefits. It is also important to remove any dependents from the plans who no longer qualify to be eligible for benefits, giving them the opportunity to enroll in coverage through COBRA. Enrollment forms removing dependents must be submitted within 30 days of the date the dependents no longer qualify for eligibility. Failing to remove the ineligible dependents within 30 days may, upon further investigation, jeopardize the employees health insurance coverage in accordance with the Florida Blue plan document.

Group Insurance Eligibility

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

Employee Eligibility

Employees are eligible to participate in The City's insurance plans if they are full-time employees. Full-time employees (defined as regularly scheduled to work 40 hours per week) are eligible for the City's full benefits package. Employees working 30-39 hours per week may be eligible for limited benefits, including health insurance and EAP. Coverage will be effective the first of the month following 30 days of employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 1.

Separation of Employment

If employee separates employment, insurance for medical, dental and vision will continue through the end of month in which separation occurs. Other coverage may terminate on the last date of employment. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

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

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

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year the child turns age 26. Coverage may continue until the end of the calendar year the dependent child turns age 30, if the dependent meets the following requirements:

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

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

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

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

Disabled Dependents

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

- Is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- Meets eligibility for coverage under the group's insurance plans; and
- Disability existed before limiting age.

Proof of disability will be required upon request. Contact the Human Resources Department for more information.

Taxable Dependents

Employee covering adult child(ren) under employee's medical insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, the value of the coverage must be reported on the employee's W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare taxes. Contact the Human Resources Department for further details if an adult dependent child will turn age 27 in the upcoming calendar year.

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

Group Insurance Eligibility *(Continued)*

Domestic Partner Coverage

Domestic partners and their dependent child(ren) may be eligible to participate in the group insurance if officially registered as domestic partners. To be eligible for these benefits, employees must register their domestic partner as outlined in Section 9.7 Domestic Partner Benefits of the City's Personnel Policy and Procedures. IRS guidelines state the employee may not receive a tax advantage on any portion of premiums paid related to domestic partner coverage. Employees covering domestic partners and/or child dependent(s) of a domestic partner are required to pay imputed income tax on subsidy amounts and should consult a tax advisor. The below table reflects the monthly imputed income for family coverage effective October 1, 2025.

Plan	Imputed Income
BlueCare HMO 4 Plan	$933.25
BlueOptions PPO 3748 Plan	$856.46
BlueOptions PPO 3164/3165 HDHP with HSA Plan	$989.25
Humana Dental PPO Plan	$59.62

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

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

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year if the event affects the employee, spouse or dependent's coverage eligibility. Any requested changes must be directly related to the Qualifying Event.

Examples of Qualifying Events:

- Marriage or divorce
- Birth or adoption of a child
- Death of a spouse and/or other dependent(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causing eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with parent/guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Gain or loss of eligibility for State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

IMPORTANT NOTES

If employee experiences a Qualifying Event, **the Human Resources Department must be notified within 30 days of the Qualifying Event** to update coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes may be effective on the date of the event or the first of the month following the event. Newborns are effective on the date of birth. Qualifying Events will be processed in accordance with employer and carrier eligibility policy. Requests made after 30 days, will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred by an ineligible enrollee.

Medical Plan Resources

Enrolled employees and dependents have access to additional services and discounts through value added programs. Resources, such as in-network providers, benefits, deductibles, ID cards, claims and more, are easily accessed through the carrier portal and mobile App. For more details regarding medical plan resources, contact customer service.

Blue365

Blue365 is a health and wellness discount program for products and services available to all Florida Blue members including:

- ✓ 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 Florida Blue at (800) 352-2583 or visit www.blue365deals.com.

24/7 Nurseline

Florida Blue's 24-Hour Nurseline professionals can provide answers to health concerns or general health questions over the phone at no cost to employee. Members can call anytime to speak with a dedicated nurse for questions about:

- ✓ A new diagnosis
- ✓ A medical claim
- ✓ Health, medications, and prescription benefits
- ✓ Finding a primary care physician
- ✓ Managing a chronic or complex health condition (cancer, diabetes, coronary artery disease or asthma)

Dedicated nurses are available 24 hours a day, seven (7) days a week. For more information, please call Florida Blue's Nurseline at (877) 789-2583.

Healthy Addition Prenatal Program

Available to all moms-to-be, Healthy Addition Prenatal Program is a prenatal education program that is particularly important during pregnancy. Members can talk with nurses who will provide guidance for a healthy pregnancy, birth, and baby. Enjoy free educational materials and complimentary gifts. To join, please contact Florida Blue's customer service at (800) 955-7635, option 6.

Florida Blue Care Consultants

Florida Blue provides access to The Care Consultant Team (CCT) offering advice and support to help manage member's health needs and costs. The CCT can help members save time, money and make informed health care decisions through support such as:

Benefit Optimization – understanding your plan, using self-help tools, lower cost prescription options, and informed healthcare decisions to manage out-of-pocket costs. Includes referrals to disease management programs and clinical support for chronic conditions.

Clinical Support – assistance with following doctor treatment programs, healthy lifestyle guidance and access health care programs and services, and chronic condition management support.

Social and Community Support – suggestions of programs and support groups within the community, financial assistance opportunities, family support resources, including resources for transportation and lodging.

Florida Blue Care Consultant – (888) 476-2227 Monday - Friday 8am to 9pm.

Prior Authorization

Certain services will require a prior authorization to be submitted by the member's PCP to Florida Blue before they will be covered. Examples of services requiring prior authorizations include:

- Behavioral health and substance dependency
- Inpatient and outpatient admissions
- Advanced Imaging (MRI, PET, CT)
- Non generic medications

Mobile App

Mobile app provides on-the-go access to the medical benefit account to view benefits, download ID card, locate providers or view claims.

Medical Insurance

Florida Blue BlueCare HMO 4 Plan

The City offers medical insurance through Florida Blue to benefit-eligible employees working a minimum of 30 hours per week. The monthly costs for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact customer service.

Medical Insurance
Florida Blue BlueCare HMO 4 Plan
Monthly Premium

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + Family	$116.00

The Florida Blue BlueCare HMO 4 Plan requires members to select a Primary Care Physician (PCP) who coordinates medical care. Employees and dependents may choose a different PCP, and members may change their PCP at any time. The plan allows enrolled employees and dependents the freedom to see any specialist in the BlueCare network without needing a referral, with the exception of an Ophthalmologist specialist, which requires a referral. The Florida Blue BlueCare HMO 4 Plan allows employees to see any in-network provider throughout the state of Florida. With the HMO plan, employees and dependents are protected from balance billing, which means the provider cannot charge above Florida Blue's allowable amount, simply pay the copay at time of service. Services provided under the BlueCare HMO 4 Plan must be rendered by an in-network provider and facility with the exception of life-threatening emergencies.

Out-of-Area Services

Services received by non-participating providers or facilities, not in the BlueCare HMO network, are not covered. Exceptions may occur when an emergency medical condition arises. If employees or covered dependents require emergency care, emergency services regardless of location, are treated as in-network.

BlueCard Program

When traveling outside of Florida for short trips (less than 90 days) the BlueCard Program provides access to participating doctors and hospitals of other independent Blue Cross and Blue Shield providers who participate in the BlueCard Program. To use these services, the member must call their Primary Care Physician (PCP) for prior authorization for non-emergency services. For additional information contact BlueCard Customer Service at (800) 810-2583.

Away From Home Care

Florida Blue provides benefit coordination for out-of-state members participating in the BlueCare HMO Plan. This program provides coverage when an employee or dependent is temporarily residing within another Florida Blue operational area.

This AFHC program works well for dependents attending out-of-state schools, living in different service areas or long-term work assignment in another state. Under the AFHC, members receive a courtesy enrollment in a participating Host HMO and have access to a comprehensive range of benefits. An AFHC Guest Application with the Host HMO must be completed, the Host HMO will provide a member ID card, a PCP, and details on how the coverage and benefits work in the Host HMO area. For more information or to request an AFHC application, contact Florida Blue customer service at (800) 352-2583.

Florida Blue | (800) 352-2583 | www.floridablue.com

Florida Blue BlueCare HMO 4 Plan At-A-Glance

Network	BlueCare
Calendar Year Deductible (CYD)	**In-Network**
Individual	$0
Family	$0
Member Coinsurance	0%
Plan Year Out-of-Pocket Limit	
Individual	$1,500
Family	$3,000
What Applies to the Out-of-Pocket Limit?	Copays and Rx
Office Visits	
Primary Care Physician *(PCP)* Office Visit *(PCP Election Required)*	$5 Copay
Specialist Office Visit *(No Referral Required)*	$5 Copay
Preventive Services	$5 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)**	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	No Charge
Outpatient Surgery at Surgical Center	No Charge
Physician Services at Surgical Center	No Charge
Urgent Care *(Per Visit)*	$5 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	No Charge
Outpatient Hospital *(Per Visit)*	No Charge
Physician Services at Hospital	No Charge
Emergency Room *(Per Visit; Waived if Admitted)*	$50 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	No Charge
Outpatient Services *(Per Visit)*	No Charge
Outpatient Office Visit	No Charge
Prescription Drugs *(Rx)*	
Generic	$5 Copay
Preferred Brand Name	$10 Copay
Non-Preferred Brand Name	$10 Copay
Mail Order Drug *(90 Day Supply)*	2x Retail

Locate a Provider

To find a participating provider, contact customer service or visit www.floridablue.com. When searching, select the BlueCare network.

Plan References

**Quest Diagnostics is the preferred lab for bloodwork through Florida Blue.*

Important Notes

- *Services received by providers or facilities **not** in the BlueCare network, will not be covered.*
- *Visits to an opthalmologist specialist require a referral. For BlueCare members, ophthalmology services are managed through Eye Management. To coordinate care or obtain more information, please contact Eye Management at (800) 329-1152.*

Medical Insurance

The City offers medical insurance through Florida Blue to benefit-eligible employees working a minimum of 30 hours per week. The monthly costs for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following pages. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact customer service.

Medical Insurance
Florida Blue BlueOptions PPO 3748 Plan

Monthly Premium

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + Family	$220.00

The BlueOptions PPO 3748 Plan offers the convenience of referral-free access to providers as utilizing a Primary Care Physician is not required. Employees and dependents can see any doctor of choice, whenever needed. However, the PPO plan has a panel of network BlueOptions Providers designated as in-network that employees and dependents are encouraged to use. These "in-network" providers have contracts with the PPO plan, have agreed to accept certain fees for their services, and will file claims on employee and dependents behalf. Because fees are lower, the plan saves money and so do employees. Employees share more of the cost for care if employee uses "out-of-network" providers, and may be required to submit a claim form. Services rendered outside the network are subject to balance billing, which means that out-of-network providers may also bill for the difference between Florida Blue's payment and the provider or facility retail charge. In order to maximize savings, choose a provider in the Florida Blue, BlueOptions network.

Medical Insurance
Florida Blue BlueOptions PPO 3164/3165 HDHP with HSA

Monthly Premium

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + Family	$60.00

The BlueOptions PPO 3164/3165 HDHP with an HSA Plan is a Lower Premium PPO Plan, meaning members have the choice of receiving services from "in" as well as "out"-of-network providers. The major difference between a traditional PPO Plan and the Lower Premium Plan is that there are no copays or coinsurance. Members are responsible for paying the contracted rate that Florida Blue has negotiated with the provider, which also includes the cost of prescription drugs until the annual calendar year deductible/out-of-pocket maximum is reached. For example, when visiting a provider employee and dependents pay the cost of the visit, which could cost from $40 dollars upwards depending on the length of time or procedures that are carried out during the visit. If an MRI is required, employee will be responsible for the cost, which is at the negotiated rate with the facility, which could range from $700 to $1,100. Once the annual calendar year deductible/out-of-pocket maximum for in-network of $2,000 employee only and $4,000 family (out-of-network $4,000 employee only and $8,000 family) is reached, employee will no longer be required to pay for any covered medical expenses that may incur for the remainder of the calendar year. This includes provider visits and prescription drugs.

Florida Blue | (800) 352-2583 | www.floridablue.com

Florida Blue BlueOptions PPO 3748 Plan At-A-Glance

Network	BlueOptions	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$0	$500
Family	$0	$1,500
Coinsurance		
Member Responsibility	0%	40%
Plan Year Out-of-Pocket Limit		
Single	$1,500	$3,000
Family	$1,500 Per Person | $3,000 Per Family	$3,000 Per Person | Per Family $6,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$15 Copay	$20 Copay
Specialist Office Visit	$15 Copay	$20 Copay
Preventive Services	$15 Copay	$20 Copay
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	No Charge	40% After CYD
X-rays	$50 Copay	40% After CYD
Advanced Imaging *(MRI, PET, CT)*	$125 Copay	40% After CYD
Outpatient Surgery at Surgical Center	$50 Copay	40% After CYD
Physician Services at Surgical Center	$15 Copay	$20 Copay
Urgent Care *(Per Visit)*	$30 Copay	$30 Copay After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)****	Option 1: $250 Copay Option 2: $500 Copay	$750 Copay
Outpatient Hospital *(Per Visit)*	Option 1: $150 Copay Option 2: $250 Copay	$300 Copay
Physician Services at Hospital	$15 Copay	$20 Copay
Emergency Room *(Per Visit; Waived if Admitted)*	$100 Copay	$100 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)****	$250 Copay	$750 Copay
Outpatient Services *(Per Visit)*	$15 Copay	$20 Copay
Outpatient Office Visit	$15 Copay	$15 Copay
Prescription Drugs *(Rx)*		
Generic	$5 Copay	50% Coinsurance
Preferred Brand Name	$10 Copay	50% Coinsurance
Non-Preferred Brand Name	$10 Copay	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	2x Retail	50% Coinsurance

Locate a Provider

To find a participating provider, contact customer service or visit www.floridablue.com. When searching, select the BlueOptions network.

Plan References

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

***Quest Diagnostics is the preferred lab for bloodwork through Florida Blue.*

****If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility, the In-Network Option 1 inpatient Cost Share will apply to that admission.*

Important Notes

All durable medical equipent, home health services, and infusion therapy needs to go through CareCentrix. Call CareCentrix at (877) 561-9910. Refer to the HR Benefits page on the City's intranet for additional information.

Florida Blue BlueOptions PPO 3164/3165 HDHP with HSA Plan At-A-Glance

Locate a Provider

To find a participating provider, contact customer service or visit www.floridablue.com. When searching, select the BlueOptions network.

Plan References

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

***Quest Diagnostics is the preferred lab for bloodwork through Florida Blue.*

****If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility, the In-Network Option 1 inpatient Cost Share will apply to that admission.*

Network	BlueOptions	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance		
Member Responsibility	0%	0%
Plan Year Out-of-Pocket Limit		
Single	$2,000	$4,000
Family	$4,000	$8,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	CYD	CYD
Specialist Office Visit	CYD	CYD
Preventive Services	No Charge	No Charge
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	CYD	CYD
X-rays	CYD	CYD
Advanced Imaging *(MRI, PET, CT)*	CYD	CYD
Outpatient Surgery at Surgical Center	CYD	CYD
Physician Services at Surgical Center	CYD	CYD
Urgent Care *(Per Visit)*	CYD	CYD
Hospital Services		
Inpatient Hospital *(Per Admission)****	CYD	CYD
Outpatient Hospital *(Per Visit)*	CYD	CYD
Physician Services at Hospital	CYD	INN-CYD
Emergency Room *(Per Visit; Waived if Admitted)*	CYD	INN-CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	CYD	CYD
Outpatient Services *(Per Visit)*	CYD	CYD
Outpatient Office Visit	CYD	CYD
Prescription Drugs *(Rx)*		
Generic	CYD	50% Coinsurance After INN-CYD
Preferred Brand Name	CYD	50% Coinsurance After INN-CYD
Non-Preferred Brand Name	CYD	50% Coinsurance After INN-CYD
Mail Order Drug *(90-Day Supply)*	CYD	50% Coinsurance After INN-CYD

Health Savings Account

The High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollee to open a Health Savings Account (HSA). An HSA is an interest-bearing account where funds may be used to help pay employee and dependent(s) deductible, coinsurance and any qualified health care expenses not covered by the plan.

Plan Year Funding

- **Individual $59.58 Per Month**
- **Family $115.33 Per Month**

Employee may opt to fund an HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free).

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

This maximum HSA amount includes any employer and employee contributions (pre-tax or post-tax). If employee is receiving an employer contribution, employee should account for this towards the annual IRS total maximum to avoid over contributing for the tax year. Guidelines regarding the HSAs are established by the IRS.

Please Note: *Contact the Human Resources Department for further information regarding funding variations towards employer HSA contributions.*

What to Know About an HSA

- To be eligible to open an HSA, employee must be covered by a qualified high deductible health plan. Employee may not be covered under another medical plan that is not a high deductible health plan including a plan the employee's spouse may have selected where he/she has family coverage.

  Please Note: *Eligibility status to qualify for an HSA is specifically driven by employee and NOT dependents.*
- Employee owns the HSA account and will receive a account debit card. Account service fees, determined by the bank, may apply.
- No use-it or lose-it rules; funds are available to the account owner now or in the future. Participant cannot fund a traditional Health Care FSA, however, participant may fund a Limited Purpose FSA for dental and vision expenses only.
- HSA funds may earn interest.
- If the HSA is funded with employer contributions, employee may fund any balance up to the remaining IRS HSA contribution limit with pre-tax payroll deductions.
- Tax-free HSA dollars can be used for eligible health care expenses. Account balance can be accessed through the website portal.
- HSA funds are portable from one employer to another. Accumulated funds can help employee plan for retirement.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Employee's over-age dependent is not able to use the HSA account funds even if dependent is covered under the medical plan as Federal law does not recognize over-age dependents as HSA eligible qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits an employer from contributing HSA funds into the account. If employee is eligible but not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts of the tier enrolled.
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: an active employee who is covering a spouse that is enrolled in Medicare is eligible to enroll and contribute into the HSA up to the maximum contribution amounts of tier enrolled. These funds can be utilized for the active employee and spouse expenses.
- Active employee ON Medicare with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse may not contribute or receive HSA funding. Any remaining balance in the HSA account can be utilized for eligible healthcare expenses until there are no funds remaining.

HealthEquity | (877) 924-3967 | www.healthequity.com

Employee Health & Wellness Center

The City's Employee Health & Wellness Center, staffed and operated by Premise Health, is available at no cost to all benefit eligible employees and their covered dependent(s) (age two (2) and up for acute/urgent care) who are covered on the City's health plan. The Health and Wellness Center offers primary care services, including urgent and routine doctor visits, physicals, chronic disease management, radiology services, vaccinations, medications, annual health assessments, sutures, well-woman visits, lab work normally completed at family practitioners, health coaching/education, certain employment and occupational health services all at no cost to employees. The Health and Wellness Center's primary focus is to restore health and improve quality of life through skillful and personalized care in a timely, accessible, convenient manner all while reducing out of pocket healthcare costs. Some of the benefits employees and covered dependents will have when visiting the Health and Wellness Center include:

- No copays for health center visits, physicals or prescription drugs dispensed at the Center
- Less time away from work
- Quick and convenient access to licensed medical care
- Increased focus on healthcare, prevention, disease/chronic illness management and wellness
- Lower out-of-pocket medical expenses and claim costs

My Premise Health Patient Portal and Mobile App

With the secure My Premise Health patient portal and mobile app, employees can access health information from anywhere at anytime. Other benefits available include:

- Schedule same-day or next-day appointments
- View lab results as they become available
- Manage medications and request prescription refills
- Virtual appointments by phone or video
- Secure direct messaging with providers
- Complete health forms and check-in for appointments ahead of time

Electronic Medical Records (EMR)

With over half of all health systems in the U.S. using the Epic network, patient medical records are available electronically. This allows providers a more complete and accessible view of a patient's health history helping providers make more informed decisions and provide better care.

Wellness Coaching and Incentives Program

Access Premise Connect through the "Premise Inspire" icon located in the My Premise Health app under the "Incentives and Wellness" section. Designed to jump-start members towards better health, the Premise Connect portal provides reading materials, informative videos and information on healthy eating, health body/mind and much more.

No Cost Flu Shots

Flu shots are offered seasonally and do not require appointments. A variety of other vaccinations are also available by request including shingles.

No Cost Radiology Services

Radiology Services for MRI, X-ray, mammograms, CAT scans, and ultrasounds are available. Members receive priority scheduling at TGH Imaging, ALL orders must come from a Premise Health Provider.

At Home Prescription Delivery

Skip the trip to the pharmacy and receive any available prescription from the Health and Wellness Center shipped directly to you at no additional cost. Switch to prescription delivery for personalized care, convenience, synced prescriptions, and cost savings.

City of Palm Beach Gardens Employee Health & Wellness Center
4425 Burns Road, Palm Beach Gardens, FL 33410

Health Center Hours of Operation

Monday	7:00am - 4:00pm (Closed 12:00pm - 1:00pm)
Tuesday	7:00am - 4:00pm (Closed 12:00pm - 1:00pm)
Wednesday	7:00am - 4:00pm (Closed 12:00pm - 1:00pm)
Thursday	9:00am - 6:00pm (Closed 1:00pm - 2:00pm)
Friday	7:00am - 4:00pm (Closed 12:00pm - 1:00pm)
Saturday	Closed
Sunday	Closed

To schedule an appointment, please contact the Premise Health Wellness Center, visit the MyPremise Health patient portal or download the mobile app.

Premise Health Wellness Center | (561) 775-8242
members.premisehealth.com/palm-beach-gardens

Lucet Behavioral Health

Employees enrolled in the medical plan have access to behavioral health benefits such as mental health services, substance use treatment and more. Florida Blue has partnered with Lucet to provide information on topics such as depression, anxiety, substance use disorder, autism spectrum disorder and bipolar disorder. Other services available are:

- ✓ Understanding behavioral health needs and benefits
- ✓ Locating in-network behavioral health providers, specialty doctors, and treatment facilities
- ✓ Coordinating care with providers
- ✓ Community groups for support

If you have any questions or want to learn more about this program visit www.LucetHealth.com or call Lucet at (866) 287-9569.

Teladoc

The medical plan provides access to telehealth services, for convenient non-emergency medical assistance through phone or video consultation. The service should be considered when employee's primary care doctor is unavailable, after-hours or on holidays

The benefit is provided to all enrolled members. Registration should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week, on-demand access to affordable medical care.

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for non emergency urgent care and ER visits.

Teladoc | (800) 835-2362 | www.teladochealth.com

Wellness Program

The City of Palm Beach Gardens is committed to health and wellness and continues to adapt plans to encourage healthy behaviors. The Wellness Program was designed to establish an enjoyable environment that encourages and supports Live, Learn, Work and Play for a healthy, happy and fit lifestyle. This voluntary program is available to benefit-eligible employees covered on the City's health plan.

Employee Fitness Center

The Fitness Center is located adjacent to Fire Station 1, next to the Premise Health Wellness Center. The center is open 7 days a week from 6am-11pm and accessible by badge to all City employees.

Target Your Health Wellness Incentive Program

This voluntary participation based incentive program encourages employees to "Target Your Health" by adopting healthy behaviors to improve overall health and well-being. Employees must complete an Annual Health Assessment (AHA) and follow-up appointment along with a minimum of three (3) additional screenings to earn a monetary reward for participating.

Wellness Incentive

The Wellness Team is here to support employees physical fitness goals and overall health by offering all benefits-eligible employees up to $50 in reimbursement per fiscal year for qualified fitness related expenses.

Examples of eligible expenses include:

- ✓ Gym Memberships
- ✓ Race Entries and Registrations Fees
- ✓ Martial Art Classes
- ✓ Pilates and Yoga Classes
- ✓ Weight Reduction Programs
- ✓ Smoking Cessation Programs

Wellness Workshops

Employees are encouraged to attend sponsored workshops that overview wellness topics such as finance, adult, child, and infant CPR, stroke awareness, elder care, work life balance, and more.

Wellness activities and events will be announced throughout the year. The Wellness Team regularly hosts fitness challenges and prize giveaways to keep employees engaged and motivated. To learn more, visit the Wellness page on the City's intranet. For specific questions or concerns, please contact the Human Resources Department.

Dental Insurance

Humana Dental PPO Plan

The City offers dental insurance through Humana to full-time employees working 40 hours per week. The monthly costs for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact customer service.

Dental Insurance – Humana Dental PPO Plan

Monthly Premium

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

In-Network Benefits

This plan provides benefits for services received from in-network and out-of-network providers. It is an open-access plan which allows members to receive from any dental provider without selecting a Primary Dental Provider (PDP) or obtaining a specialist referral. The network of participating dental providers the plan utilizes is the Humana PPO/Traditional Preferred. These participating dental providers have contractually agreed to accept contracted fee or "allowed amount." This fee is the maximum amount a dental provider can charge a member for a service. The member is responsible for a Plan Year Deductible (PYD) and coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Humana PPO/Traditional Preferred provider. Humana reimburses out-of-network services based on what it determines as the Usual and Customary (U&C) Charge. The U&C is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between Humana's U&C and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Plan Year Deductible

The Plan Year Deductible accumulates from October 1 - September 30. The plan requires a $50 individual or a $100 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Plan Year Benefit Maximum

The maximum benefit the plan will pay for each covered member is $1,500 for in-network and out-of-network services combined. All services, including preventive, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member is responsible for any charges until next plan year.

Mobile App

Mobile app provides on-the-go access to the dental benefit account to view benefits, download ID card, locate providers or view claims.

Humana | (800) 233-4013 | www.humana.com

Humana Dental PPO Plan At-A-Glance

Network	PPO/Traditional Preferred	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network***
Single	$50	
Family	$100	
Waived for Class I Services?	Yes	
Plan Year Benefit Maximum		
Per Member	$1,500	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(3 Per Plan Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(3 Per Plan Year)*		
Complete X-rays *(1 Every 5 Years)*		
Bitewing X-rays *(1 Set Per Plan Year)*		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% After PYD	Plan Pays: 75% After PYD *(Subject to Balance Billing)*
Simple Extractions		
Oral Surgery		
Periodontal Services		
Endodontics *(Root Canal Therapy)*		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 60% After PYD	Plan Pays: 45% After PYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,500	
Benefit *(Dependent Children Up To Age 19)*	Plan Pays: 50% Deductible Waived	Plan Pays: 50% Deductible Waived *(Subject to Balance Billing)*

Locate a Provider

To find a participating provider, contact customer service or visit www.humana.com. When searching, select the PPO/Traditional Preferred network.

Plan References

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

Important Notes

- *Each covered family member may receive up to three (3) routine cleanings per plan year covered under the preventive benefit.*
- *For any dental work expected to cost $500 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs.*
- *Waiting periods, age limitations and benefit frequency limitations may apply.*

Vision Insurance

Superior Vision Plan

The City offers vision insurance through Superior Vision to full-time employees working 40 hours per week. The monthly costs for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the carrier's summary plan document or contact customer service.

Vision Insurance – Superior Vision Plan

Monthly Premium

Tier of Coverage	Employee Cost
Employee Only	$5.44
Employee + Family	$14.72

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employee and covered dependent(s) may select any network provider who participates in the Superior Vision Superior National network. At the time of service, routine vision examinations and basic optical needs will be covered according to the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

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

Plan Year Deductible

No plan year deductible.

Plan Year Out-of-Pocket Maximum

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

Mobile App

Mobile app provides on-the-go access to the vision benefit account to view benefits, download ID card, locate providers or view claims.

Superior Vision | (800) 507-3800 | www.superiorvision.com

Superior Vision Plan At-A-Glance

Network		Superior National	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 Copay	Up to $28 Reimbursement
Contact Lens Exam *(Fit and Follow-Up)*	Standard Lens	No Charge After $25 Copay	Not Covered
	Specialty	Up to $50 Allowance After $25 Copay	Not Covered
Materials		$25 Copay	Reimbursement Based of Type of Service
Retinal Imaging		Up to $39 Copay	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		No Charge After $25 Materials Copay	Up to $28 Reimbursement
Bifocal		No Charge After $25 Materials Copay	Up to $40 Reimbursement
Trifocal		No Charge After $25 Materials Copay	Up to $53 Reimbursement
Frames			
Allowance		Up to $125 Allowance After $25 Materials Copay 20% Off Balance Over $125	Up to $58 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $210 Reimbursement
Elective	Conventional	Up to $135 Allowance 20% Off Balance Over $135	Up to $100 Reimbursement
	Disposable	Up to $135 Allowance 10% Off Balance Over $135	Up to $100 Reimbursement

Locate a Provider

To find a participating provider, contact customer service or visit www.superiorvision.com. When searching, select the Superior National network.

Plan References

**Contact lenses are in lieu of spectacle lenses.*

Important Notes

- *Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.*
- *Members can choose from a diverse network of private practice and retail providers, such as Target Optical, Sears Optical, Walmart Optical, JCPenney Optical, LensCrafters, Costco, Sams Club, Visionworks, Eyeglass World, Pearle Vision, 1800contacts and contactsdirect.com.*

Flexible Spending Accounts

The City offers Flexible Spending Accounts (FSA) administered through HealthEquity. The FSA plan year is from October 1 to September 30 and must be re-elected every year.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee can set aside pre-tax earnings for healthcare (FSA) and work related day care (DCFSA) expenses reducing taxable income and increasing spending power. Funds are deducted automatically and available for reimbursement of eligible expenses not covered by insurance. Participating employee must re-elect contribution amount to be deducted each plan year. There are three (3) types of FSAs:

- **Health Care FSA:** Available to eligible employee **not** enrolled in the Florida Blue BlueOptions PPO 3164/3165 HDHP with an HSA. Covers medical, dental, and vision expenses that are not paid by insurance.
- **Limited Purpose FSA:** Available to eligible employee enrolled in the Florida Blue BlueOptions PPO 3164/3165 HDHP with an HSA. A Limited Purpose Health Care FSA may be used for qualified dental and vision expenses.
- **Dependent Care FSA:** Covers day care expenses for qualified dependents necessary for employee and legal spouse, if married, to work.

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,300. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

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

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

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

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

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

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

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

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

**These items are eligible expenses under the Limited Purpose FSA.*

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

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- FSA enrollment must be re-elected every year.
- A 90 day run out period allows until December 31st to submit for reimbursement of eligible expenses incurred during the plan year.
- Enrollment is only available during Open Enrollment, New Hire Orientation, or Qualifying Life Events.
- Funds cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Only expenses for services received are eligible for reimbursement.
- Reimbursed expenses cannot be covered by insurance or other compensation.
- Domestic partners' healthcare expenses are ineligible as they are not qualified dependents under Federal law.

Filing a Claim

Claim Form

Submit a completed claim form with a receipt online or via the mobile app. The IRS requires participant to keep documentation for a minimum of one (1) year.

Debit Card

FSA participants will receive a debit card. The card is accepted at many medical providers and pharmacies allowing direct payment instead of reimbursement requests. HealthEquity may request supporting documentation for purchases; failure to provide supporting documentation when requested may result in card suspension. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

Mobile App

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

- File a Claim
- Make Payments
- View Account Activity
- Upload Receipts

HERE'S HOW IT WORKS!

An employee earning $50,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $41.66 based on a 24 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

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

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

Claims Submission
Online Member Portal or Mobile App

Using a Smartphone or Mobile Device

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

Use EZ Receipts:

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

HealthEquity | (877) 924-3967 | www.healthequity.com

Employee Assistance Program

The City cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Aetna Resources for Living to support employees and their families with personal and work related challenges. The EAP is available to all benefit eligible employees working a minimum of 30 hours per week. Licensed mental health professionals are available 24 hours a day, 7 days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members/domestic partners confidential mental health support and counseling including six (6) visits with a specialist, per person, per issue, per year, online material/tools and webinars. EAP services include:

- ✓ Child & Elder Care Assistance
- ✓ Legal & Financial Resources
- ✓ Grief, Stress, Depression & Anxiety Support
- ✓ Work & Family Issues
- ✓ Substance Abuse Counseling

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), (attendance, compliance) may be shared to referring supervisor/manager. The referring supervisor/manager will not receive case details. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Aetna Resources for Living | (888) 238-6232
www.resourcesforliving.com | Username: pbgfl | Password: eap

Basic Life and AD&D Insurance

Basic Term Life Insurance

The City provides Basic Term Life insurance at no cost through Ochs/Securian for eligible full-time employees working a minimum of 40 hours per week with a benefit amount of 2x annual earnings up to a maximum of $100,000.

Accidental Death & Dismemberment Insurance (AD&D)

In addition and at no cost to employee, Accidental Death & Dismemberment (AD&D) Insurance equal to the Basic Term Life benefit amount, when death is a result of an accident. Partial payouts for qualifying injuries.

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- › Reduces by 35% of the benefit amount at age 65
- › Reduces by 50% of the benefit amount at age 70

Basic Dependent Life Insurance

In addition to Basic Term Life and AD&D Insurance, the City provides Basic Dependent Life insurance to all benefit eligible employees at no cost, at the following benefit levels:

Basic Spouse Life Insurance

- Spouse Life insurance coverage is a benefit amount of $5,000

Basic Dependent Child(ren) Life Insurance

- Dependent Child(ren) Life insurance coverage is a flat amount of $5,000 for each dependent child from birth to age 26.

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through the Human Resources Department. Beneficiary forms are available on the City's intranet and must be submitted to the Human Resources Department directly.

Ochs/Securian | (800) 392-7295 | www.securian.com

Line of Duty Death Benefit

The City provides a Line of Duty Death benefit at no cost for public safety officers through Ochs/Securian. The death benefit is $100,000 or 100 percent of the AD&D insurance benefit, whichever is less, when suffering a loss for which an AD&D insurance benefit is payable and which is the result of a line of duty accident.

Ochs/Securian | (800) 392-7295 | www.securian.com

Voluntary Life Insurance

Voluntary Employee Life Insurance

Eligible full-time employee working a minimum of 40 hours per week may elect to purchase additional Life insurance on a voluntary basis through Ochs/Securian. Voluntary Life insurance offers coverage for employee, spouse and/or dependent child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $250,000.**

- Units can be purchased in increments of $10,000 to the maximum of $750,000.

Voluntary Spouse Life Insurance

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

- Units can be purchased in increments of $5,000 to a maximum of $250,000 not to exceed 100% of the employee's Basic and Voluntary Life coverage amount combined.

Voluntary Life Insurance Rate Table

Monthly Premium

Age Bracket	Employee/Spouse *(Rate Per $1,000 of Benefit)*
< 30	$0.085
30-34	$0.102
35-39	$0.119
40-44	$0.151
45-49	$0.292
50-54	$0.460
55-59	$0.800
60-64	$1.240
65-69	$1.340
> 69	$1.820

Voluntary Dependent Child(ren) Life Insurance

- Coverage may be purchased for dependent child(ren) from birth up to the date in which the dependent child reaches age 26 in the amount of $10,000 or $15,000.
- Monthly cost for Voluntary Dependent Child(ren) Life coverage elected is $2.00 for $10,000 in coverage or $3.00 for $15,000 in coverage for any eligible dependent child(ren) enrolled.

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through the Human Resources Department. Beneficiary forms are available on the City's intranet and must be submitted to the Human Resources Department directly.

Ochs/Securian | (800) 392-7295 | www.securian.com

Short Term Disability

The City provides Short Term Disability (STD) insurance at no cost to all eligible full-time employees working 40 hours per week. The STD benefit covers a percentage of weekly earnings if employee is disabled due to an illness or non-work related injury.

Short Term Disability (STD) Benefits

- STD pays 60% of weekly earnings.
- General employees must be disabled for 7 consecutive days prior to becoming eligible for benefits (known as the elimination period). Benefits begin on the 8th day of disability.
- PBA and IAFF members must be disabled for 14 consecutive days prior to becoming eligible for benefits (known as the elimination period). Benefits begin on the 15th day of disability.
- The maximum benefit period is 26 weeks.
- Employee deemed unable to return to work after the STD 26 week maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- If an employee is unable to return to work after the 26 weeks are exhausted, separation from employment and then may be transferred to LTD.

Please contact the Human Resources Department for further information about the STD Benefit.

Long Term Disability

The City provides Long Term Disability (LTD) insurance at no cost to all eligible full-time General and PBA Communication employees working 40 hours per week through Ochs/Madison National Life. The LTD benefit covers a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Long Term Disability (LTD) Benefits

General, PBA Communications, and IAFF Community Risk Employees

- LTD pays 60% of monthly earnings up to a maximum of $5,000 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The maximum benefit period is determined by age at disability.

Ochs/Madison National Life
(800) 832-7295 | www.madisonnationallife.com

Voluntary Long Term Disability

The City offers Voluntary Long Term Disability (LTD) insurance to all eligible full-time Police Officers and Firefighters working 40 hours per week through Ochs/Madison National Life. The LTD benefit covers a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Voluntary Long Term Disability (LTD) Benefits

Police Officers and Firefighters

- LTD pays 60% of monthly earnings up to a maximum of $1,500 per month.
- Employee must be disabled for 180 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 181st day of disability.
- Employee may continue to be eligible for partial benefits if employee returns to work on a part-time basis.
- The maximum benefit period is two (2) years.

Voluntary Long Term Disability Rate Table

Monthly Premium

Age Bracket	Employee (Rate Per $100 of Benefit)
< 34	$0.102
35-39	$0.135
40-44	$0.166
45-49	$0.339
50-54	$0.568
55-59	$1.042
60+	$1.146

Ochs/Madison National Life
(800) 832-7295 | www.madisonnationallife.com

Retirement

Florida Retirement System (FRS)

The City participates in the Florida Retirement System (FRS) Plan for all full-time and regular part-time general employees, PBA Communications and IAFF Community Risk. New hires are given eight (8) months following the employees month of hire to elect membership in the FRS Pension or FRS Investment plan. New employees that do not make a plan election risk being defaulted into a plan in accordance with their membership class.

Employees must contribute 3% of their gross compensation on a pretax basis toward their retirement plan.

FRS Pension Plan

The FRS Pension Plan is a traditional, defined-benefit retirement plan. Vesting occurs after eight (8) years of service. Pension plan benefits are based on a formula that considers years of service, employee class participation and income history.

FRS Investment Plan

The FRS Investment Plan is a defined contribution plan where employees allocate employer and employee contributions to available investments. Vesting occurs after one (1) year of service. The benefit for this plan is based on how much money is contributed to an employees account and how well that money grows over time when invested. Employees choose from several available payout options when the benefit is taken.

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

Roth IRA and 457 Plan

Employees may choose to contribute a portion of their earnings into the MissionSquare Retirement Roth IRA or 457 Plan. These plans can help employees supplement the retirement benefits from the FRS.

Roth IRA – Contributions into the plan are on an after-tax basis. The benefit of this plan is that withdrawals are tax-free after age 59 1/2, as long as employee has had the account for at least five (5) years. In 2025, employee may contribute up to $7,000, and if over age 50 employee can contribute up to $8,000.

457 Plan – Contributions into the 457 plan allows participants to make after-tax Roth contributions. While they don't reduce the participant's taxable income for the year, future withdrawals may be tax free. The 2025 normal contribution Limit for 457 plan is 100% of compensation or $23,500, whichever is less. Age 50 catch-up contributions, up to $7,500 more than the normal limit ($31,000 maximum).

Employees can join these plans at any time throughout the year with no minimum limit. For additional information, or to enroll in either plan, schedule an appointment with the City's MissionSquare Retirement Specialist, Steve Feigelis.

MissionSquare Retirement | (800) 669-7400 | www.missionsq.org
MissionSquare Retirement Specialist: Steve Feigelis
(202) 759-7058 | Email: sfeigelis@missionsq.org

Retiree Insurance Benefits

Employees retiring from the City may elect to continue certain group insurance benefits for themselves and their covered dependents. Retirees must make their election at time of retirement and will be responsible for paying 100% of the benefits cost. Retirees who do not elect insurance at time of retirement are not eligible to enroll during any future open enrollment period. Retirees and their covered dependents currently participating in the City's medical insurance plan will have the following options: 1) continue to participate in the medical plan to include use of the Employee Health and Wellness Center, or 2) decline the medical plan and use the Employee Health Center only, at a reduced rate determined annually. Employees should contact the Human Resources Department for assistance with understanding these benefit options.

Supplemental Benefits

Aflac

Aflac offers a variety of voluntary supplemental benefit plans on a voluntary basis and premiums paid by payroll deduction. Aflac pays money directly to employee, regardless of what other benefit plans they may have, Available Aflac plans include:

- Group Accident Plan
- Group Critical Illness
- Group Hospital Indemnity

To learn more about these Aflac plans and/or to schedule a personal appointment, contact the City's Aflac Agent, Kimberly Sahoy.

Aflac | www.aflac.com
Agent: Kimberly Sahoy | (786) 340-1640
Kimberly_Sahoy@us.aflac.com

Financial Resources

Pathways

The City offers employees and dependents an opportunity for Financial Resources assistance and education available through Pathways. Services include but are not limited to:

- ✓ Loans Against Retirement Accounts
- ✓ Cash in Personal Leave Hours
- ✓ Financial Literacy Workshops
- ✓ Public Service Loan Forgiveness Program
- ✓ Counseling Resources
- ✓ Housing Assistance

Please contact the Human Resources Department for questions or visit www.pbgfl.gov/pathways for more information regarding the Financial Resources benefit.

Onsite Childcare: Riverside Youth Enrichment Center

The City of Palm Beach Gardens is proud to offer guaranteed spots for employees at our onsite childcare facility, Riverside Youth Enrichment Center. With no waitlists and year-round availability, this program provides exceptional early learning at significant discount compared to market rates.

Riverside serves children from infants through VPK, offering:

- ✓ Smaller teacher-to-child ratios than required by law
- ✓ Experienced, fully vetted teachers who are also City employees
- ✓ A convenient location near City Hall, police, and fire stations

In addition, the City's Recreation Department offers:

- ✓ Discounted aftercare with pickup from a set list of schools. Please consult the staff at Riverside before registration to determine if your school is a pick-up site.
- ✓ Discounted summer, winter break, and school's-out camps for employees

This outstanding childcare benefit supports working families while prioritizing safety, learning, and convenience.

Claims, Billing & Benefit Assistance

If employees have questions on claims, provider bills or would like general information on any of the employee benefits provided, please contact the Risk Strategies Service Team.

The Risk Strategies Service Team works directly with the City and its employees to provide claims and benefits service and will assist employees with their concerns. Please remember, this is in addition to the City's Human Resources Department and is not replacing assistance employee may need from the Human Resources Department.

Employee may contact a claims specialist by:

1. Email: pbg@risk-strategies.com

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

OR

2. Call: (800) 244-3696

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

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

At Risk Strategies, our goal is to be your advocate and ensure issues are resolved as quickly as possible.

Notes

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

PALM BEACH Gardens

RISK strategies
PUBLIC SECTOR

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

FINAL
Last Modified: July 11, 2025 11:03 AM