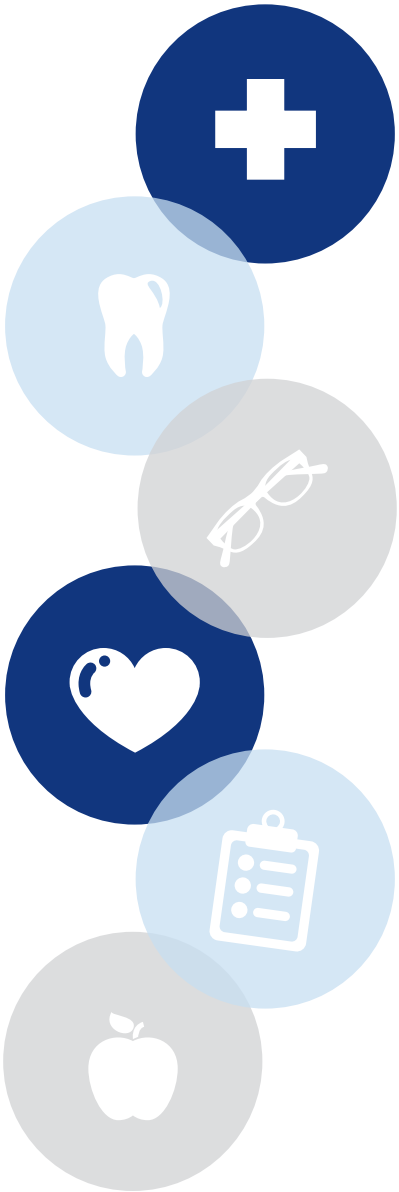
20 26

EMPLOYEE BENEFIT HIGHLIGHTS

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 County reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

Contact Information

	Human Resources Manager	Sherri Bennett	Phone: (863) 402-6509 Email: sbennett@highlandsfl.gov
	Human Resources Generalist	Elaine Wood	Phone: (863) 402-6972 Email: ewood@highlandsfl.gov
	HR Benefits Coordinator	Jennifer Ramos	Phone: (863) 402-6809 Email: jramos@highlandsfl.gov
	Dedicated Cigna Representative	Samary Villanueva	Phone: (863) 402-6853 Email: samary.camuy@cigna.com
	Online Benefit Enrollment	Bentek Support	(888) 5-Bentek (523-6835) Email: support@mybentek.com app.mybentek.com/highlandscountygov
	Medical Insurance	Cigna Healthcare	Phone: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail-Order Program	Express Scripts Through Cigna Healthcare	Phone: (800) 835-3784 www.mycigna.com
	Telehealth	MDLIVE Through Cigna Healthcare	Phone: (888) 726-3171 www.mycigna.com
HSA	**Health Savings Account (HSA)**	P&A Group	Phone: (800) 688-2611 www.padmin.com
	Dental Insurance	Cigna Healthcare	Phone: (800) 244-6224 www.mycigna.com
	Vision Insurance	Davis Vision	Phone: (800) 999-5431 www.davisvision.com
FSA	**Flexible Spending Accounts**	P&A Group	Phone: (800) 688-2611 www.padmin.com
	Employee Assistance Program	Cigna EAP	Phone: (877) 622-4327 www.mycigna.com | Employer ID: hcbcc
	Employee Assistance & Wellness Support	ComPsych GuidanceResources	Phone: (800) 344-9752 www.guidanceresources.com | Registration Web ID: NYLGBS
	Emergency Responders Support Line	Cigna Healthcare	Phone: (877) 505-3671 www.mycigna.com | Employer ID: hcbcc
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	Phone: (800) 362-4462 www.mynylgbs.com
	Voluntary Life and AD&D Insurance	New York Life Group Benefit Solutions	Phone: (800) 362-4462 www.mynylgbs.com
	Voluntary Short Term Disability Insurance	New York Life Group Benefit Solutions	Phone: (888) 842-4462 www.mynylgbs.com
	Voluntary Long Term Disability Insurance	New York Life Group Benefit Solutions	Phone: (888) 842-4462 www.mynylgbs.com
	Supplemental Benefit	Aflac	Agent: Diana Casey | Office: (863) 382-2076 Email: diana_casey@us.aflac.com
	Claims, Billing and Benefit Assistance	Gehring Group	Phone: (800) 244-3696 Email: highlandscounty@gehringgroup.com

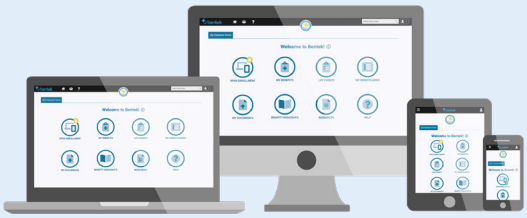
Introduction

The County of Highlands 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 County 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 Human Resources.

Online Benefit Enrollment

The County provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Life Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report qualifying life events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center

- ✓ Visit **app.mybentek.com/highlandscountygov**
- ✓ Sign in with existing username and password or select "Create an Account."
- ✓ If needed, select "Forgot Username/Password" to recover login credentials.
- ✓ Use the Launchpad to review enrollment, explore options, and make changes or update beneficiary designations.

For technical issues directly related to using the EBC, contact:
support@mybentek.com
(888) 5-Bentek (523-6835)

Hours of Operation: Monday through Friday 8:30 am - 5:00 pm (EST)

Scan QR Code to Access Bentek

Group Insurance Eligibility

The County's group insurance plan year is January 1 through December 31.

Employee Eligibility

Employees are eligible to participate in the County's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first of the month following 30 days of employment. For example, if employee is hired on April 10, then the effective date of coverage will be June 1.

Separation of Employment

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

Dependent Eligibility

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

- A natural child
- A stepchild
- A legally adopted child
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Age Requirements

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

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.

Disabled Dependents

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

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

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

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Flexible Spending Accounts (FSA), and/or certain supplemental policies are deducted 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 the Open Enrollment Period 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. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

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

Summary of Benefits and Coverage

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

From:	Human Resources
Address:	600 S. Commerce Ave. Suite B233 Sebring, Florida 33870
Phone:	(863) 402-6500
Website:	app.mybentek.com/highlandscountygov

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting Human Resources.

Medical Insurance

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

Medical Insurance – Cigna Open Access Plus (OAP) HDHP Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$1,084.00	$1,084.00	$0.00	$0.00
Employee + Spouse	$1,425.00	$1,084.00	$341.00	$170.50
Dual Spouse	$1,425.00	$1,425.00	$0.00	$0.00
Employee + Child(ren)	$1,357.00	$1,084.00	$273.00	$136.50
Employee + Family	$1,582.00	$1,084.00	$498.00	$249.00
Dual Family	$1,582.00	$1,425.00	$157.00	$78.50

Medical Insurance – Cigna Open Access Plus (OAP) Buy-Up Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$1,463.00	$1,184.00	$279.00	$139.50
Employee + Spouse	$1,960.00	$1,184.00	$776.00	$388.00
Dual Spouse	$1,960.00	$1,525.00	$435.00	$217.50
Employee + Child(ren)	$1,859.00	$1,184.00	$675.00	$337.50
Employee + Family	$2,187.00	$1,184.00	$1,003.00	$501.50
Dual Family	$2,187.00	$1,525.00	$662.00	$331.00

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

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.

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.

Healthy Rewards

Healthy Rewards is provided automatically to members at no additional cost. The program offers access to discounted health and wellness programs at participating providers. To access the Healthy Rewards program, visit the Wellness section on www.myCigna.com or call (800) 870-3470.

Cigna One Guide

Cigna One Guide service can help employees and dependents make smarter informed choices and get the most from the medical plan enrolled. One Guide personal support, tools and reminders can help employees stay healthy and save money. One Guide team can help with the following:

- Understand Health Plan & Coverage
- Access to Care (find in-network providers; one-on one support for complex health situations)
- Save and Earn (obtain cost estimates and service comparisons)

Start using Cigna One Guide today by myCigna app, or call Cigna at (800) 244-6224 to talk with a personal guide.

Health Assessment

Cigna's Health Assessment is a short, simple, online assessment that individuals complete to create a personalized health profile and action plan. Each health assessment triggers personalized Cigna health advocacy interventions designed to simultaneously optimize the individual's health.

Register at www.mycigna.com, select Wellness, then select My Health Assessment.

My Health Assistant

Let's face it; everyone has health and wellness goals, but reaching them can sometimes seem impossible. Whether looking for help with weight, tobacco or stress management, My Health Assistant is here for employees. With My Health Assistant, employees have access to an online, interactive coaching program to help make those big changes possible in a fun, flexible and motivating way.

Register at www.mycigna.com, select Wellness and select Health Assistant or call (855) 246-1873.

Health Information Line

The 24-Hour Health Information Line (HIL) assists individuals in understanding the right level of treatment at the right time. Trained nurses are available 24 hours a day, seven (7) days a week, 365 days a year to provide health and medical information and assistance on available resources. For more information call (800) 244-6224.

Cigna Healthy Pregnancy Mobile App

The Cigna Healthy Pregnancy app helps members manage pregnancy and supports baby's first two years. It offers tracking tools, educational videos, relaxation exercises, and personalized reminders, along with an expanded library on health, safety, and pediatrics. Developed by medical experts and updated annually, the app follows national guidelines and is easy to access with a myCigna login. Available on the App Store and Google Play.

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

Telehealth

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

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

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

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

Cigna Healthcare
Phone: (888) 726-3171 | www.mycigna.com

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

Locate a Provider

To find a participating provider, contact customer service or visit www.mycigna.com. When searching, select the Open Access Plus network.

Plan References

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

***Family Plan Deductible: Once a family member has met their individual deductible, the plan will begin to pay for covered services for that person. The plan will not pay for covered services for the other family members until the family deductible has been met.*

****Family Out-of-Pocket Maximum: Once a family member has met their individual out-of-pocket maximum, this family member will have no additional cost share for the rest of the calendar year. The rest of the covered family members must continue to satisfy their out-of-pocket until the family out-of-pocket maximum is met.*

†LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using another lab, please confirm the lab is contracted with the plan's network before receiving services.

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Individual	$2,500	$4,000
Family**	Individual: $2,500 | Family: $5,000	Individual: $4,000 | Family: $8,000
Coinsurance		
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Maximum		
Individual	$5,500	$8,000
Family***	Individual: $5,500 | Family: $11,000	Individual: $8,000 | Family: $16,000
What Applies to the Out-of-Pocket Maximum?	Coinsurance, Deductible and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	20% After CYD	40% After CYD
Specialist Office Visit *(No Referral Required)*	20% After CYD	40% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)*†	20% After CYD	40% After CYD
X-rays	20% After CYD	40% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD	40% After CYD
Outpatient Surgery in Surgical Center	20% After CYD	40% After CYD
Physician Services at Surgical Center	20% After CYD	40% After CYD
Urgent Care *(Per Visit)*	20% After CYD	40% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After CYD	40% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD	40% After CYD
Physician Services at Hospital	20% After CYD	40% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	20% After CYD	20% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	20% After CYD	40% After CYD
Outpatient Services *(Per Visit)*	20% After CYD	40% After CYD
Outpatient Office Visit	20% After CYD	40% After CYD
Prescription Drugs *(Rx)*		
Generic	20% After CYD	40% After CYD
Preferred Brand Name	20% After CYD	40% After CYD
Non-Preferred Brand Name	21% After CYD	40% After CYD
90 Day Supply *(Mail Order/Retail Pharmacy)*	20% After CYD/ 21% After CYD	Not Covered

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

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out of Network***
Individual	$2,000	$4,500
Family**	Individual: $2,000 | Family: $4,500	Individual: $4,500 | Family: $13,500
Coinsurance		
Member Responsibility	20%	50%
Calendar Year Out-of-Pocket Maximum		
Individual	$5,000	$9,000
Family**	Individual: $5,000 | Family: $10,000	Individual: $9,000 | Family: $18,000
What Applies to the Out-of-Pocket Maximum?	Coinsurance, Deductible, Copays, and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$60 Copay	50% After CYD
Specialist Office Visit	$75 Copay	50% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)*†	No Charge	50% After CYD
X-rays	No Charge	50% After CYD
Advanced Imaging *(MRI, PET, CT)*	$250 Copay	50% After CYD
Outpatient Surgery in Surgical Center	$55 Copay	50% After CYD
Physician Services at Surgical Center	No Charge	50% After CYD
Urgent Care *(Per Visit)*	$60 Copay	$60 Copay
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After CYD	$500 PAD‡ + 50% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD	50% After CYD
Physician Services at Hospital	No Charge	50% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$250 Copay	$250 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	No Charge	50% Coinsurance
Outpatient Services *(Per Visit)*	No Charge	50% Coinsurance
Outpatient Office Visit	No Charge	50% Coinsurance
Prescription Drugs *(Rx)*		
Individual/Family (Calendar Year Deductible for Rx)	$500	$500
Generic	$10 Copay	50% Coinsurance
Preferred Brand Name	$45 Copay	50% Coinsurance
Non-Preferred Brand Name	$60 Copay	50% Coinsurance
90 Day Supply *(Mail Order/Retail Pharmacy)*	$20/$90/$120 Copay	Not Covered

Locate a Provider

To find a participating provider, contact customer service or visit www.mycigna.com. When searching, select the Open Access Plus network.

Plan References

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

***Family Plan Deductible: Once a family member has met their individual deductible, the plan will begin to pay for covered services for that person. The plan will not pay for covered services for the other family members until the family deductible has been met.*

****Family Out-of-Pocket Maximum: Once a family member has met their individual out-of-pocket maximum, this family member will have no additional cost share for the rest of the calendar year. The rest of the covered family members must continue to satisfy their out-of-pocket until the family out-of-pocket maximum is met.*

† LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using another lab, please confirm the lab is contracted with the plan's network before receiving services.

‡PAD = Per Admission Deductible

Health Savings Account (HSA)

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

Plan Year Funding

Employer HSA Funding Allotment for 2026:

- **Individual:**$100 per month

Please Note: *Funding amount will be pro-rated for new hires and qualifying events.*

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).

- 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 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 they have family coverage. 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 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 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 and with a spouse NOT enrolled in Medicare: An active employee who is enrolled in Medicare and covering a spouse may not contribute or receive HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

P&A Group
Phone: (800) 688-2611 | www.padmin.com

Health Savings Account: Understanding HSAs

Question	HSAs Health Savings Accounts
What is an HSA?	Employee who enrolls in the Cigna Open Access Plus (OAP) High Deductible Health Plan (HDHP) will receive a Health Savings Account (HSA) funded by the County and employee may also additionally fund the account with tax-free dollars. HSA funds can be used for qualified IRS 213 expenses. Go to http://www.irs.gov for a listing of 213 expenses.
How much is funded into the account?	Please contact Human Resources for further information regarding funding variations towards employer HSA contributions. Employee may opt to additionally fund an HSA with tax-free dollars up to $4,400 (individual coverage) or $8,750 (family coverage) during the 2026 plan year. ***Please Note:*** *Funding amount will be pro-rated for new hires and qualifying events.*
How are the funds accessed?	HSA funds can be accessed via: 1) Health Savings Account Debit Card, or 2) Transfer funds from employee's HSA to personal checking or savings account through Bill Pay on www.padmin.com
What happens to unused funds at the end of the 2026 Plan Year?	The year-end balance remains in the HSA Account and continues to earn interest.There are no use-it or lose-it rules as the funds are in the account when needed, now or in the future.
What happens to unused funds if employee discontinues participation in an HSA Plan, separates employment, or retires from the County?	Employee owns the HSA funds from day one and decides how and when to spend the money. HSA funds are portable from one employer to another.
What are some examples of qualified expenses that would be eligible for reimbursement?	HSA funds can be used to meet and pay the calendar year deductible, coinsurance, copays and any qualified health care expenses not covered by the medical plan. Most covered services count towards the deductible, including prescriptions costs, physician visits, dental visits, hospital visits, laboratory work, etc. All expenses must be medically necessary.
Can an employee have an HSA AND a Flexible Spending Account (FSA)?	No, an employee cannot fund a traditional Health Care FSA, however, employee may fund a Limited Purpose FSA for dental and vision expenses only. For more information on FSAs, please refer to the Flexible Spending Accounts page.

P&A Group
Phone: (800) 688-2611 | www.padmin.com

Dental Insurance

Cigna DPPO Base Plan

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

Dental Insurance – Cigna DPPO Base Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$17.00	$17.00	$0.00	$0.00

Please Note: *Dependent coverage is not available on the plan.*

In-Network Benefits

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

Please Note: *Total network dental members have the option to utilize a dentist that participates in either Cigna's Advantage or Total network. However, members that use the Cigna Advantage network will see additional cost savings from the added discount that is allowed for using an Advantage network provider. Members are responsible for verifying whether the treating dentist is an Advantage or Total dentist.*

Out-of-Network Benefits

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

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the DPPO Base plan will pay for employee is $1,000 for in-network and out-of-network services combined. All preventive services accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

Mobile App

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

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

Cigna DPPO Base Plan At-A-Glance

Network	Total	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	Does Not Apply	
Calendar Year Benefit Maximum		
Per Member	$1,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100%	Plan Pays: 100% *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Calendar Year)*		
Complete X-rays *(1 Every 3 Years)*		
Bitewing X-rays *(2 Per Calendar Year)*		

Locate a Provider

To find a participating provider, contact customer service or visit www.mycigna.com. When searching, select the Total 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

- *Member may receive up to two (2) routine cleanings per calendar year covered under the preventive benefit.*
- *Benefit frequency limitations may apply to certain services.*

Dental Insurance

Cigna DPPO Premium Plan

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

Dental Insurance – Cigna DPPO Premium Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$38.00	$17.00	$21.00	$10.50
Employee + Spouse	$68.00	$17.00	$51.00	$25.50
Employee + Child(ren)	$84.00	$17.00	$67.00	$33.50
Employee + Family	$105.00	$17.00	$88.00	$44.00

In-Network Benefits

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

Please Note: *Total network dental members have the option to utilize a dentist that participates in either Cigna's Advantage or Total network. However, members that use the Cigna Advantage network will see additional cost savings from the added discount that is allowed for using an Advantage network provider. Members are responsible for verifying whether the treating dentist is an Advantage or Total dentist.*

Out-of-Network Benefits

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

Calendar Year Deductible

The DPPO Premium 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.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the DPPO Premium plan will pay for each covered member is $5,000 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 will be responsible for future charges until next calendar 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.

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

Cigna DPPO Premium Plan At-A-Glance

Network	Total	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$100	
Waived for Class I Services	Yes	
Calendar Year Benefit Maximum		
Per Member	$5,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Calendar Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Calendar Year)*		
Complete X-rays *(1 Every 3 Years)*		
Bitewing X-rays *(2 Per Calendar Year)*		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Oral Surgery		
Anesthetics		
Class III Services: Major Restorative Care		
Endodontics *(Root Canal Therapy)*	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Periodontal Services		
Crowns		
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Dependent Children Up To Age 19)*	Plan Pays: 50%	Plan Pays: 50% *(Subject to Balance Billing)*

Locate a Provider

To find a participating provider, contact customer service or visit www.mycigna.com. When searching, select the Total 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 two (2) routine cleanings per calendar year covered under the preventive benefit.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

Vision Insurance

Davis Vision Plan

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

Vision Insurance – Davis Vision Plan

Tier of Coverage	Total Premium Per Month	County Portion Per Month	Employee Portion Per Month	Employee Portion Per Pay Period (24)
Employee Only	$5.49	$0.00	$5.49	$2.75
Employee + Spouse	$10.93	$0.00	$10.93	$5.47
Employee + Child(ren)	$11.47	$0.00	$11.47	$5.74
Employee + Family	$15.98	$0.00	$15.98	$7.99

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 Davis Vision network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

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

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

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

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.

Davis Vision
Phone: (800) 999-5431 | www.davisvision.com

Davis Vision Plan At-A-Glance

Network	Davis Vision	
Services	**In-Network**	**Out-of-Network**
Eye Exam	$10 Copay	Up to $40 Reimbursement
Retinal Imaging	Up to $39 Copay	Not Covered
Contact Lenses *(Fitting and Follow-up)*	15% Off Retail	Not Covered
Frequency of Services		
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses		
Single	$25 Copay	Up to $40 Reimbursement
Bifocal	$25 Copay	Up to $60 Reimbursement
Trifocal	$25 Copay	Up to $80 Reimbursement
Frames		
Allowance	Up to $150 Retail Allowance; Then 20% Off Balance Over $150	Up to $50 Reimbursement
Contact Lenses*		
Non-Elective *(Medically Necessary)*	Covered at 100%	Up to $225 Reimbursement
Elective	Up to $150 Retail Allowance; Then 15% Off Balance Over $150	Up to $105 Reimbursement

Locate a Provider

To find a participating provider, contact customer service or visit www.davisvision.com.

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 may receive up to an additional $50 Retail Allowance towards frames at participating Visionworks locations.

Flexible Spending Accounts

The County offers Flexible Spending Accounts (FSA) administered through P&A Group. The FSA plan year is from January 1 to December 31.

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

Health Care FSA: Available to eligible employee **not** enrolled in the Cigna Open Access Plus (OAP) HDHP Plan 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 Cigna Open Access Plus (OAP) HDHP Plan with an HSA. A Limited Purpose Health Care FSA may be used for qualified dental and vision expenses.

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.

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
- ✓ Experimental Medical Treatment
- ✓ 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 (applies to Health Care FSA and Limited Purpose FSA)

- A 75 day grace period allows additional time to incur claims and use remaining funds on eligible expenses after the plan year ends.
- Once the grace period ends, an additional 90 day run out period allows reimbursement of eligible expenses incurred during the plan year and/or grace period.
- After run out period ends any unused funds still remaining in the account will be forfeited.
- Enrollment is only available during the Open Enrollment Period, New Hire Orientation, or Qualifying Life Events.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Funds cannot be transferred between FSAs.
- 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 by mail, fax, 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. P&A Group 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.

Mobile App

Mobile app provides on-the-go access to the FSA benefit account to view account activity, file a claim and 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, the insurance premiums and 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	-$9,895
After Tax Expenses	- $0	-$1,000
Spendable Income	$39,372	$39,175
Tax Savings	**$197**	

Please Note: *Be conservative when estimating health care expenses. IRS regulations state that any unused funds remaining in an Health Care 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
Mail: 17 Court Street, Suite 500, Buffalo, NY 14202
Fax: (877) 855-7105

P&A Group
Phone: (800) 688-2611 | www.padmin.com

Employee Assistance Program

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

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes three (3) visits with a specialist, per person, per issue, per year, telephonic consultation, online material/tools and webinars. EAP offers counseling services on issues such as:

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

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or Human Resources Department), 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. The referring supervisor will not 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.

To Access Services

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

Cigna Behavioral Health
Phone: (877) 622-4327 | www.mycigna.com | Access Code: hcbcc

Employee Assistance & Wellness Support

The County offers, at no cost to eligible employees, an Employee Assistance & Wellness Support Program through ComPsych GuidanceResources. The program is strictly confidential and provides employee and household family members, professional counseling 24 hours a day, seven (7) days a week for handling life's demands. Members are able to request a referral for three (3) visits with a specialist.

Online or phone support, advice or referrals for community services on topics such as:

- ✓ Legal Consultation
- ✓ Stress
- ✓ Elder Care
- ✓ Child Care
- ✓ Pet Care
- ✓ Estate Planning
- ✓ Work-Life Balance
- ✓ Well-being Coaching
- ✓ Financial Guidance
- ✓ Burnout

Please Note: *This program is strictly confidential and no information will be shared with employer.*

ComPsych
Phone: (800) 344-9752 | Registration Web ID: NYLGBS
www.guidanceresources.com

Emergency Responders Support Line

The County supports First Responders and offers, at no cost, an Emergency Responders Support Line through Cigna. The support line is strictly confidential and provides employee and household family members, with support, solutions, qualified referrals to local resources, and online tools 24 hours a day, seven (7) days a week. Members are able to request a referral for three (3) visits with a specialist, per person, per issue, per year, telephonic consultation.

The support line can help with concerns and challenges such as:

- ✓ Coping with loss and trauma
- ✓ Post-traumatic stress
- ✓ Suicide prevention
- ✓ Emotional support for family members
- ✓ Stress and anxiety
- ✓ Financial concerns
- ✓ Childcare, senior care and pet care referrals
- ✓ And more

Emergency Responders Support Line
Phone: (877) 505-3671 | Employer ID: hcbcc | www.mycigna.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

The County provides Basic Term Life insurance at no cost to all eligible employees, through New York Life. Eligible employees will receive a benefit amount of $15,000.

Accidental Death & Dismemberment Insurance

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

Age Reduction Schedule

Benefit amounts are subject to the following age reduction schedule:

- Reduces to 65% of the benefit amount at age 65
- Reduces to 40% of the benefit amount at age 70

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

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

Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

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

2026 Open Enrollment: Eligible employees have the opportunity to purchase Voluntary Employee Life and AD&D insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $150,000.

New Hires may purchase Voluntary Employee Life and AD&D insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $150,000.**

- Units can be purchased in increments of $10,000 to the maximum of five (5) times annual salary or $300,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 40% of the benefit amount at age 70

Voluntary Life and AD&D Insurance Rate Table

Monthly Premium

Age Bracket *(Based on Employee Age)*	Employee/Spouse *(Rate Per $1,000 of Benefit)*
< 25	0.08
25-29	0.09
30-34	0.11
35-39	0.12
40-44	0.15
45-49	0.24
50-54	0.40
55-59	0.64
60-64	0.78
65-69	1.34
70-74	2.09
> 75	2.41

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

Voluntary Spouse Life and AD&D Insurance

2026 Open Enrollment: Eligible employees have the opportunity to purchase Voluntary Spouse Life and AD&D insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $25,000.

New Hires may purchase Voluntary Spouse Life and AD&D insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $25,000**.

- Employee must participate in the Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $5,000 to a maximum of $150,000 not to exceed 50% of the employee's Voluntary Life coverage amount.

Spouse Life insurance coverage is subject to the same age reduction schedule as employee with coverage terminating at age 70.

Voluntary Dependent Child(ren) Life and AD&D Insurance

- Employee must participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- Children from live birth to six (6) months old may be covered for a $500 benefit.
- Children from six (6) months to age 26 may be covered for units of $5,000 or $10,000.
- Monthly cost for Voluntary Dependent Child(ren) Life coverage elected is $0.16 per $1,000 for each eligible dependent child.

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

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

Voluntary Short Term Disability

The County offers Voluntary Short Term Disability (STD) insurance to all eligible employees through New York Life. The STD benefit pays employee a percentage of weekly earnings if employee becomes disabled due to an illness or non-work related injury.

Voluntary Short Term Disability (STD) Benefits

- STD provides a benefit of 60% of employee's weekly earnings up to a benefit maximum of $1,500 per week.
- Employee must be disabled for 14 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 15th day after the employee is disabled due to non-work related injury or illness.
- 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).
- Benefits may be reduced by other income.
- Disability benefits are taxable.

New York Life Group Benefit Solutions
Phone: (888) 842-4462 | www.mynylgbs.com

Voluntary Long Term Disability

The County offers Voluntary Long Term Disability (LTD) insurance to all eligible employees through New York Life. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or non-work related injury.

Voluntary Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit 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 based on age at the time of disability.
- Benefits may be reduced by other income.

New York Life Group Benefit Solutions
Phone: (888) 842-4462 | www.mynylgbs.com

Supplemental Benefits

Aflac

The County offers a variety of supplemental plans through Aflac that may be purchased separately on a voluntary basis. Premiums are paid by payroll deduction. Aflac pays money directly to member, regardless of what other insurance plans member may have. All plans are portable if employee changes jobs or retires. To learn more about these plans or to schedule a personal appointment, contact the local Aflac agent.

Available plans include:

- Accident
- Cancer
- Critical Illness
- Hospital Indemnity
- Short Term Disability

Aflac
Agent: Diana Casey | Office: (863) 382-2076
Email: diana_casey@us.aflac.com

Claims, Billing & Benefit Assistance

If employees have questions on claims, receive bills from providers which they do not understand or would like general information on any of the employee benefits provided, please contact the dedicated Cigna representative, Samary Villanueva or the Gehring Group.

Cigna and the Gehring Group Service Team works directly with the County and its employees to provide claims and benefits service and will assist employees with their concerns. Please remember this is in addition to the the County's Human Resources and is not replacing assistance employee may need from HR.

Employee may contact the dedicated Cigna representative, Samary Villanueva, by:

1. Email: Samary.Camuy@cigna.com

Please include your name, contact information and a brief description of the issue. The Cigna dedicated representative will respond via email or phone call to gather additional information.

OR

2. Call: (863) 402-6853 (ext 6853 if internal)

When calling, please identify yourself as an employee of the Highlands County and the Cigna dedicated representative will assist with questions or concerns.

Samary's office hours are Monday through Thursday, 8:00am - 5:00pm. The Gehring Group is available to assist with any claims, billing or benefit quesitons in addition to the Cigna dedicated representative, if necessary. Our office hours are Monday through Friday, 8:30am - 5:00pm. If calling after office hours, please leave a message indicating you are a Highlands County employee who would like to speak to a Claims Specialist. Please leave full name, contact information and a brief message and Samary or Gehring Group will be in contact with you the following business day.

Remember, you may contact your Cigna dedicated representative Samary.Camuy@cigna.com or email the Gehring Group team at: Highlandscounty@gehringgroup.com.

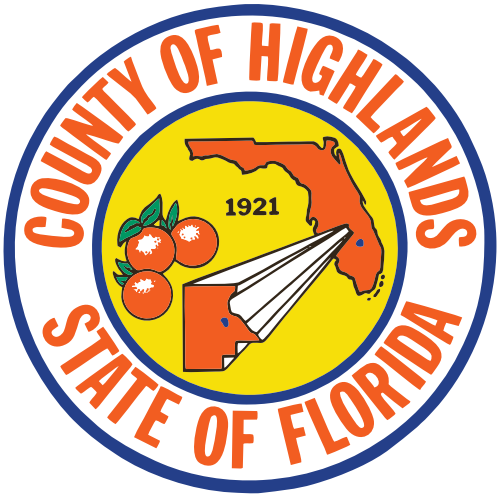
Our goal is to ensure that these items are resolved as quickly as possible .

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.

Notes

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



RISK strategies | GEHRING GROUP
A RISK STRATEGIES COMPANY

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

FINAL
Last Modified: October 14, 2025 11:30 AM