2025 EMPLOYEE BENEFIT HIGHLIGHTS

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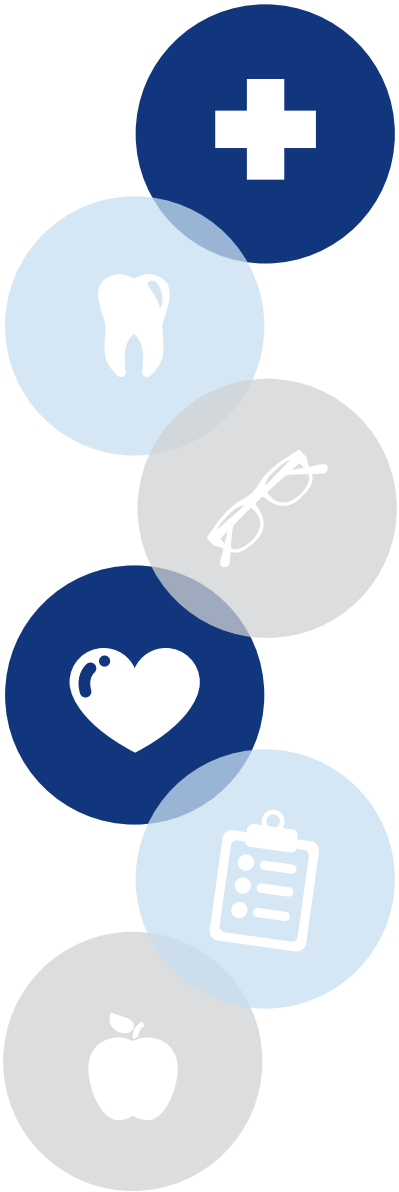

This guide is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. PBSO reserves the right to amend, modify or terminate the plan at any time. This booklet should not be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

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Contact Information

	Benefits Division		Phone: (561) 688-3551 Benefits: Option 1; Then Option 1 Email: BenefitsDiv-Benefits@PBSO.org
	Health and Wellness Center	Cigna	West Palm Beach: (561) 242-3009 Wellington: (561) 402-8600 Delray Beach: (561) 526-0400 Belle Glade: (561) 992-1132
	Medical Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.myCigna.com Group #: 3339276
	Prescription Drug Coverage & Mail-Order Program	Cigna/Express Scripts	Customer Service: (800) 835-3784 www.myCigna.com
	Part-Time Medical Coverage	Symetra/ Benefit Select Administration	Customer Service: (800) 497-3699 www.symetra.com
	Telehealth	MDLIVE through Cigna	Customer Service: (888) 726-3171 www.myCigna.com
	Dental Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.myCigna.com Group #: 3339276
	Vision Insurance	Humana	Customer Service: (877) 398-2980 www.humana.com Group #: 772426
	Flexible Spending Accounts	Health Equity	Customer Service: (855) 774-7441 www.healthequity.com
	Employee Assistance Program	Cigna	Customer Service: (888) 371-1125 www.myCigna.com
	Long Term Disability Insurance	New York Life Group Benefit Solutions	Customer Service: (800) 362-4462 www.mynylgbs.com
	Basic Life and AD&D Insurance	New York Life Group Benefit Solutions	PBSO Benefits Division Phone: (561) 688-3551, Option 1; Then Option 1
	Voluntary Life Insurance	New York Life Group Benefit Solutions	PBSO Benefits Division Phone: (561) 688-3551, Option 1; Then Option 1
	Supplemental Benefits	Preferred Legal	Customer Service: (888) 577-3476 www.preferredlegal.com
		Identity Theft - iDefend	Customer Service: (801) 724-6211
		Washington National	Customer Service: (800) 541-2254 my.washingtonnational.com
	Retirement	Florida Retirement System (FRS)	Pension Customer Service: (844) 377-1888 | www.frs.fl.gov Investment/Financial Guidance: (866) 446-9377 | www.myfrs.com
		Lincoln Financial Group (457 Deferred Compensation)	Customer Service: (800) 234-3500 www.lfg.com
		Heritage Financial Consultants, LLC	Agent: Alejandro Jerez Phone: (305) 570-1816

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Introduction

The Palm Beach County Sheriff's Office (PBSO) 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 PBSO Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations. 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 Benefits Division.

Group Insurance Eligibility

JANUARY 01

Palm Beach County Sheriff's Office group insurance plan year is January 1 through December 31.

Employee Eligibility

Employees are eligible to participate in PBSO 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 60 days of employment. For example, if employee is hired on April 12, then the effective date of coverage will be July 1.

Part-time Employees

Part-time employees working a maximum of **29 hours** per week are eligible for minimum essential coverage. Coverage will be effective the first of the month following 60 days of employment.

Separation of Employment

If employee separates employment from PBSO, insurance for medical, dental and vision will continue through the end of the pay cycle 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/domestic partner and/or dependent child(ren) of the employee 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 (Florida State Statute)
- A child* for whom legal guardianship (court order) has been awarded to the participant or the participant's spouse/domestic partner

**Employee must provide a signed court order to the Benefits Division.*

Dependent Age Requirements

Medical and Dental Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent (taxable dependent) may continue to be covered on the medical and dental plans to the end of the calendar year in which the OAD reaches age 30, if the dependent meets the following requirements:

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

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

Please see OAD Taxable Dependents if covering eligible dependents over 27 years old.

Disabled Dependents Requirements

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

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

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

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Group Insurance Eligibility *(Continued)*

Over Age Taxable Dependents

Employee may choose to continue coverage for an adult dependent child through the end of the calendar year in which the child reaches age 26 on a pre-tax basis. Beginning January 1 of the following year the dependent no longer qualifies for coverage on a pre-tax basis, but can be covered as an Overage Dependent (OAD)*. By choosing to cover an OAD, employee will be subjected to imputed income and post-tax premium deductions. Imputed income is the dollar value attributable to the cost of coverage of an OAD who can remain on the group medical and dental plans through the end of the calendar year in which the OAD reaches age 30.

**To qualify for OAD benefits, employee is required to complete PBSO's Affirmation of Age Based Dependent and provide a copy of dependent child's birth certificate and social security card. The dependent may be added on a post-tax basis if there is a Qualifying Event. Contact the Benefits Team for more details.*

Domestic Partner Coverage

Domestic Partners (DP)* may be eligible to participate in PBSO's group insurance plans if employee provides a copy of a Certificate of Partnership, issued by the county in which employee resides. Employee may elect coverage for a DP during the New Hire, Open Enrollment Periods or if there is a Qualifying Event. By choosing to cover a DP, employee will be subjected to imputed income and post-tax premium deductions. Imputed income is the dollar value attributable to the cost of coverage of a DP who can remain on the group medical, dental and vision plans until the partnership is dissolved or a qualifying event.

**Employee covering DPs and/or dependent child(ren) of a DP, is required to provide PBSO with copies of the DP and/or dependent child(ren) birth certificates and social security cards.*

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

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

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

IMPORTANT NOTES

If employee experiences a Qualifying Event, the **Benefits Division must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes will be effective the date of 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.

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PBSO Health & Wellness Center

The Health and Wellness Centers operated by Cigna On-site Health®, LLC are available for employees and covered dependents, Monday through Saturday.

The Wellness Centers are established to provide all Palm Beach County Sheriff's Office employees and their covered dependents cost-free access to the highest quality medical care for acute and chronic conditions.

Below are examples of services provided by our Wellness Centers:

- ✓ Colds
- ✓ Coughs
- ✓ Flu
- ✓ Fevers
- ✓ Minor Injuries and Burns
- ✓ Cuts and Bad Scrapes
- ✓ Broken Bones
- ✓ Well Care
- ✓ Immunizations
- ✓ Physicals
- ✓ Maintenance
- ✓ Prescriptions

PBSO Wellness Centers provide more services than a typical primary care provider and urgent care center.

- ✓ They value your privacy by providing you with closed exam rooms.
- ✓ They have an on-site blood draw and x-ray - no need to go anywhere else.
- ✓ Some prescription medications may be available with your office visit.

IMPORTANT NOTE

If employee wishes to change Primary Care Physician (PCP) to the Wellness Center, please contact PBSO on-site Cigna representatives:

Brenda Rodriguez: (561) 688-3555
DaNetra Scott: (561) 688-3287
BenefitsDiv-Cigna@PBSO.org

Exclusively for the Palm Beach County Sheriff's Office
All employees may use the Health & Wellness Centers (full-time & part-time).

Health & Wellness CENTER
Operated by Cigna Onsite Health, LLC Cigna

West Palm Beach Office

2101 Centrepark West Drive, Suite 175, West Palm Beach, FL 33409
Phone: (561) 242-3009 | Fax: (561) 242-3010

Health Center Hours of Operation
(Dependents Ages 2 and Older)

Monday, Wednesday and Friday	7:00 a.m. – 5:00 p.m.
Tuesday and Thursday	9:00 a.m. – 7:00 p.m.
Saturday	9:00 a.m. – 1:00 p.m.
Sunday	CLOSED

Wellington Office

1039 S. State Road 7, Suite 104, Wellington, FL 33414
Phone: (561) 402-8600 | Fax: (561) 402-8597

Health Center Hours of Operation
(Dependents Ages 2 and Older)

Monday, Wednesday and Friday	7:00 a.m. – 5:00 p.m.
Tuesday and Thursday	9:00 a.m. – 7:00 p.m.
Saturday	9:00 a.m. – 1:00 p.m.
Sunday	CLOSED

Delray Beach Office

15200 Jog Road, Suite D3-5, Delray Beach, FL 33446
Phone: (561) 526-0400 | Fax: (561) 526-0378

Health Center Hours of Operation
(Dependents Ages 2 and Older)

Monday, Wednesday and Friday	7:30 a.m. – 4:00 p.m.
Tuesday and Thursday	9:00 a.m. – 5:30 p.m.
Saturday and Sunday	CLOSED

Belle Glade Office

38771 James Wheeler Way, Belle Glade, FL 33430
Phone: (561) 992-1132 | Email: PBSO-BelleGlade@cigna.com

Health Center Hours of Operation
(Dependents Ages 2 and Older)

Monday *(RN Assisted Virtual Visits)*	7:30 a.m. – 4:00 p.m.
Thursday *(Provider Available)*	9:00 a.m. – 5:30 p.m.
Tuesday, Wednesday, Friday, Saturday and Sunday	CLOSED

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Medical Insurance

PBSO offers medical 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 medical plans, please refer to the Summary of Benefits and Coverage (SBC) document on PBSO employee portal or contact Cigna's customer service.

Medical Insurance – Cigna Open Access Plus In-Network Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$19.59
Employee + One (Child)	$62.24
Employee + One (Spouse)	$62.24
Employee + Two or More	$90.39

Medical Insurance – Cigna Open Access Plus Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$48.83
Employee + One (Child)	$93.24
Employee + One (Spouse)	$93.24
Employee + Two or More	$132.97

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

Cigna Onsite Service Representatives

Cigna Onsite Service Representatives are here to assist employees:

- ✓ Understand plan benefits
- ✓ Find in-network doctors and arrange care
- ✓ Investigate denied claims and assist to resolve them

Call or Email Questions

Brenda Rodriguez | Phone: (561) 688-3555 | Email: RodriguezB@pbso.org
DaNetra Scott | Phone: (561) 688-3287 | Email: ScottDa@pbso.org
Email: BenefitsDiv-Cigna@PBSO.org

Part-Time Employee Medical Coverage

Minimum Essential Coverage (MEC) Medical Plan

The Palm Beach County Sheriff's Office provides, at no cost to all active **part-time employees**, a Minimum Essential Coverage (MEC) Medical Plan through Symetra. Part-time employees are automatically enrolled in the Symetra plan. Dependent children, under age 26, are eligible to enroll in the MEC plan at a cost. Spouse and Domestic Partners are **not** eligible for coverage. Covered benefits are paid at 100% when an in-network provider is used. Additionally, Select Benefits, a fixed-payment medical benefit, is available to help reduce out-of-pocket costs for services not included in the MEC plan. To find a participating provider, contact Symetra's customer service or visit www.multiplan.com/symetra.

For further details, please visit the PBSO Employee Portal, SharePoint and click on Benefits Division.

Select Benefit Administrators

Customer Service: (800) 497-3699 | www.symetra.com

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 the Open Enrollment Period. The summary is an important item in understanding employee's benefit options.

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 on the employee SharePoint page.

If there are any questions about the plan offerings or coverage options, please contact the Benefits Division at (561) 688-3551, Option 1; Then Option 1.

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Medical Plan Resources

Cigna Healthcare offers all medical enrolled employees and dependents additional services and discounts through its value added programs. For more details regarding other medical plan resources, please contact Cigna's customer service at (800) 244-6224 or visit www.myCigna.com.

Mobile App

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

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

24 Hour Help Information Hotline (800) 244-6224

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

Healthy Rewards Program

Cigna's Healthy Rewards is provided automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Member can log on to www.myCigna.com and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- ✓ Vision Care
- ✓ Lasik Vision Correction Services
- ✓ Fitness Club Discounts
- ✓ Nutrition Discounts
- ✓ Hearing Care

MotivateMe® Perks Program

Cigna provides access to MotivateMe Perks Incentive program. Employees who complete the Health Risk Assessment (HRA) online at www.myCigna.com are able to participate in events, earn gift cards and a chance to win incentives:

- ✓ Exclusive Family Events
- ✓ Earn up to $200* in Gift Cards
- ✓ Chance to win Admin Days

MotivateMe Perks is administered through Cigna. Register online at www.myCigna.com or through the myCigna app. To learn more, please contact Cigna Onsite Representatives, Brenda Rodriguez or DaNetra Scott at benefitsdiv-cigna@pbso.org.

Please Note: *MotivateMe program redeemed points are subject to tax withholding.*

Health Risk Assessment (HRA)

The Sheriff's Office and Cigna care about the health of employees and offer an annual Health Risk Assessment (HRA) that can be completed online at www.myCigna.com. Completing the HRA, provides employees the opportunity to learn about their health and potential health issues.

Registration is easy.
If you have never registered for www.myCigna.com:

1. Go to www.myCigna.com
2. Register with your Cigna ID, SSN or take the personal questionnaire
3. Go to the "My Health" tab
4. Click on the Health Assessment tile
5. Complete your assessment

If you have already registered for myCigna.com:

1. Log on to myCigna.com
2. Go to the "My Health" tab
3. Click on the Health Assessment tile
4. Complete your assessment

For questions or technical issues please contact technical support at (800) 853-2713.

Telehealth

Cigna provides access to telehealth services as part of PBSO medical plans. MDLIVE is a convenient phone and video consultation company that provides immediate medical assistance for non-emergency situations.

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 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, such as:

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

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact MDLIVE through Cigna Healthcare.

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

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Cigna Open Access Plus In-Network Plan At-A-Glance

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.myCigna.com. When completing the necessary search criteria, select Open Access Plus network.

Plan References

**Specialists in the Cigna Care Network (CCN) offer a lower copay than a Non-Cigna Care Network provider*

***LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna for your plan prior to receiving services*

Important Notes

- *Services received by providers or facilities **not** in the Cigna Open Access Plus network, will not be covered.*
- *There is a separate $5,350/$9,700 per calendar year pharmacy out-of-pocket limit, that does not accumulate towards the medical calendar year out-of-pocket limit.*

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	Does Not Apply
Family	Does Not Apply
Coinsurance	
Member Responsibility	Does Not Apply
Calendar Year Out-of-Pocket Limit	
Single	$2,500
Family	Per Person: $2,500 | Per Family: $7,500
What Applies to the Out-of-Pocket Limit?	Copays
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$20 Copay
Specialist Office Visit *(CCN/Non-CCN)**	$40 Copay / $55 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)***	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	$150 Copay *(Per Scan; Per Day)*
Outpatient Surgery at Surgical Center	$250 Copay
Physician Services at Surgical Center	No Charge
Urgent Care *(Per Visit)*	$100 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	$1,000 Copay
Outpatient Hospital *(Per Visit)*	$250 Copay
Physician Services at Hospital	No Charge
Emergency Room *(Per Visit; Waived if Admitted)*	$400 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	$1,000 Copay
Outpatient Services *(Per Visit)*	No Charge
Outpatient Office Visit	$40 Copay
Prescription Drugs *(Rx)*	
Calendar Year Out-of-Pocket Limit for Rx Costs	$5,350 Single / $9,700 Family
Generic	$10 Copay
Preferred Brand Name	$35 Copay
Non-Preferred Brand Name	$65 Copay
Mail Order Drug *(90-Day Supply)*	2x Copay

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Cigna Open Access Plus Plan At-A-Glance

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out of Network***
Single	$1,000	$1,000
Family	Per Person: $1,000 | Per Family: $3,000	Per Person: $1,000 | Per Family: $3,000
Coinsurance		
Member Responsibility	10%	40%
Calendar Year Out-of-Pocket Limit		
Single	$2,500	$2,500
Family	Per Person: $2,500 | Per Family: $7,500	Per Person: $2,500 | Per Family: $7,500
What Applies to the Out-of-Pocket Limit?	Deductible and Coinsurance	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	10% After CYD	40% After CYD
Specialist Office Visit *(CCN/Non-CCN)***	10% / 20% After CYD	40% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)****	10% After CYD	40% After CYD
X-rays	10% After CYD	40% After CYD
Advanced Imaging *(MRI, PET, CT)*	10% After CYD	40% After CYD
Outpatient Surgery at Surgical Center	10% After CYD	40% After CYD
Physician Services at Surgical Center	10% After CYD	40% After CYD
Urgent Care *(Per Visit)*	10% After CYD	10% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	10% After CYD	$750 PAD***** + 40% After CYD
Outpatient Hospital *(Per Visit; Pre-Authorization may be required)*	10% After CYD	40% After CYD
Physician Services at Hospital	10% After CYD	40% After CYD
Emergency Room *(Per Visit)*	10% After CYD	10% After INN CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	10% After CYD	$750 PAD***** + 40% After CYD
Outpatient Services *(Per Visit)*	10% After CYD	40% After CYD
Outpatient Office Visit	10% After CYD	40% After CYD
Prescription Drugs *(Rx)*		
Calendar Year Out-of-Pocket Limit for Rx Costs	$5,350 Single / $9,700 Family	
Generic	$10 Copay	40% Coinsurance
Preferred Brand Name	$35 Copay	40% Coinsurance
Non-Preferred Brand Name	$65 Copay	40% Coinsurance
Mail Order Drug *(90-Day Supply)*	2x Copay	40% Coinsurance

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.myCigna.com. When completing the necessary search criteria, select Open Access Plus network.

Plan References

***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.*

***Specialists in the Cigna Care Network (CCN) offer a lower copay than a Non-Cigna Care Network provider.*

****LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna for your plan prior to receiving services.*

*****PAD: Per Admission Deductible*

Important Notes

- *There is a separate $5,350/$9,700 per calendar year pharmacy out-of-pocket limit, that does not accumulate towards the medical calendar year out-of-pocket limit.*

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Dental Insurance

Cigna DHMO Dental Care Access Plan

PBSO 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 summary plan document or contact Cigna's customer service.

Dental Insurance – Cigna DHMO Dental Care Access Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + One *(Child)*	$7.87
Employee + One *(Spouse)*	$7.87
Employee + Two or More	$14.14

In-Network Benefits

The DHMO Dental Care Access plan is an **in-network only plan** that requires all services be received by a Primary Dental Provider (PDP). Employee and dependent(s) may select any participating dentist in the **Cigna Dental Care Access network** to receive covered services. There is no coverage for services received out-of-network.

The DHMO Dental Care Access plan's schedule of benefits is set forth in the Patient Charge Schedule (fee schedule) which is highlighted on the following page. Please refer to the summary plan document on PBSO employee portal (Benefit tab) for a complete list of charges and covered benefits.

Out-of-Network Benefits

The DHMO plan **does not cover** any services rendered by out-of-network facilities or providers.

Calendar Year Deductible

There is **no** calendar year deductible.

Calendar Year Benefit Maximum

There is **no** benefit maximum.

Mobile App

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

- View Benefits
- Download Member ID cCards
- Locate a Provider
- View Claims

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

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Cigna DHMO Dental Care Access Plan At-A-Glance

Network		Cigna Dental Care Access	
Calendar Year Deductible (CYD)		**In-Network**	
Per Member		Does Not Apply	
Per Family			
Waived for Class I Services?			
Calendar Year Benefit Maximum			
Per Member		Does Not Apply	
Class I Services: Diagnostic & Preventive Care		**Code***	**In-Network**
Routine Oral Exam *(4 Per Year)*		D0150	No Charge
Routine Cleanings *(2 Per Year)*		D1110/D1120	
Complete X-rays *(1 Every 3 Years)*		D0210	
Bitewing X-rays *(2 Films)*		D0272	
Class II Services: Basic Restorative Care			
Fillings *(Amalgam)*		D2140	$6 Copay
Fillings *(Resin, 3 Surface Posterior)*		D2393	$82 Copay
Simple Extractions *(Erupted Tooth or Exposed Root)*		D7140	$12 Copay
Surgical Extractions *(Impacted, Completely Bony)*		D7240	$185 Copay
Root Canal Therapy *(Molar)***		D3330	$440 Copay
Periodontal Scaling and Root Planning		D4341	$110 Copay
Class III Services: Major Restorative Care			
Crowns *(Porcelain Fused to Metal)*		D2752	$400 Copay
Bridges		D5213/D5214	$625 Copay
Dentures		D5110/D5120	$535 Copay
Class IV Services: Orthodontia			
Benefit	Child *(Up to Age 19)*	D8670	$2,280 Copay
	Adult	D8670	$3,000 Copay
Treatment Planning/Records		D8660	$67 Copay

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.myCigna.com. When completing the necessary search criteria, select Cigna Dental Care Access network.

Plan References

** D = Diagnostic Code*
*** Excluding final restoration.*

Important Notes

- *Two (2) routine cleanings per plan year covered under the preventive benefit. Members can also receive two (2) additional cleanings at the charge of a copay.*
- *Prior authorization is not required for specialty referrals for Endodontic, Orthodontic and Pediatric Services.*
- *Waiting periods and age limitations may apply.*

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Dental Insurance

Cigna Total DPPO Plan

PBSO 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 summary plan document or contact Cigna's customer service.

Dental Insurance – Cigna Total DPPO Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + One *(Child)*	$13.47
Employee + One *(Spouse)*	$13.47
Employee + Two or More	$18.54

In-Network Benefits

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

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

Out-of-Network Benefits

Out-of-network benefits are used when member receives services from a non-participating Cigna 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 Cigna Total DPPO plan deductibles are required to be met before most benefits will begin. Members who select a Cigna DPPO Advantage provider will have a $50 individual or $150 family in-network deductible. Members who select a Cigna DPPO provider will have a $100 individual or $300 family in-network deductible. Out-of-network services require a $100 individual or $300 family deductible. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the Cigna Total DPPO plan will pay for each covered member is $1,000 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. Download the myCigna mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

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

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Cigna Total DPPO Plan At-A-Glance

Network	Total Cigna DPPO		
	Cigna DPPO Advantage	Cigna DPPO	
Calendar Year Deductible (CYD)	**In-Network**	**In-Network**	**Out-of-Network***
Per Member	$50	$100	$100
Per Family	$150	$300	$300
Waived for Class I Services?		Yes	
Calendar Year Benefit Maximum			
Per Member	$1,000	$1,000	$1,000
Class I Services: Diagnostic & Preventive Care			
Routine Oral Exam *(2 Per Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Year)*			
Complete X-rays *(1 Every 3 Years)*			
Bitewing X-rays *(2 Sets Per Year)*			
Class II Services: Basic Restorative Care			
Fillings	Plan Pays: 100% After CYD	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions			
Oral Surgery			
Endodontics *(Root Canal Therapy)*			
Periodontal Services			
Anesthetics			
Class III Services: Major Restorative Care			
Crowns	Plan Pays: 60% After CYD	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Bridges			
Dentures			
Class IV Services: Orthodontia			
Lifetime Maximum	$1,500	$1,500	$1,500
Benefit *(Adult/Child)*	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.myCigna.com. When completing the necessary search criteria, select Total Cigna DPPO network.

Plan References

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

Important Notes

- *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.*

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Vision Insurance

Humana Vision 130 Plan

PBSO offers vision insurance through Humana 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 summary plan document or contact Humana's customer service.

Vision Insurance - Humana Vision 130 Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Cost
Employee Only	$0
Employee + One or More	$5.56

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 **Humana Insight 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 Humana Insight network. When going out of network, the provider will require payment at the time of appointment. Humana 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. Download the Humana mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Humana | Customer Service: (877) 398-2980 | www.humana.com

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Humana Vision 130 Plan At-A-Glance

Network		Humana Insight	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$10 Copay	Up to $30 Reimbursement
Contact Lens Exam *(Includes Fit and Follow-Up)*	Standard	Up to $55 Allowance	Not Covered
	Premium	10% Discount Off Retail	Not Covered
Retinal Imaging		Up to $39 Allowance	Not Covered
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		$15 Copay	Up to $25 Reimbursement
Bifocal		$15 Copay	Up to $40 Reimbursement
Trifocal		$15 Copay	Up to $60 Reimbursement
Frames			
Allowance		Up to $130 Retail Allowance; 20% Off Balance Over $130	Up to $65 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $200 Reimbursement
Elective *(Lenses)*	Conventional	Up to $130 Retail Allowance; 15% Off Balance Over $130	Up to $104 Reimbursement
	Disposable	Up to $130 Allowance	Up to $104 Reimbursement

Locate a Provider

To search for a participating provider, contact Humana's customer service or visit www.humana.com. When completing the necessary search criteria, select Insight 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.

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Flexible Spending Accounts

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

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

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,300. 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.

Minimum contribution amount $300.

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 may potentially 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.

Minimum contribution amount $300.

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 Health Care FSA reimbursement include, but not limited to, the following:

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

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

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Flexible Spending Accounts *(Continued)*

FSA Guidelines

- The Health Care FSA allows a 2½ month grace period after the end of the plan year. The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends Once the grace period ends, any unused funds still remaining in the account will be forfeited.
- The Health Care FSA has a 120 day run out period at the end of the plan year (April 30, 2026) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year and/or grace period.
- Employee can enroll in an FSA only during the Open Enrollment Period, New Hire Orientation or Qualifying Events.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners' healthcare expenses are not eligible for reimbursement in the employee FSA. As Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

Healthcare FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. Health Equity may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

Example, 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	$30,000
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**	

Mobile App

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

- File a Claim
- View Item for Eligibility
- View Account Activity
- Upload Receipts

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."***

HealthEquity | Phone: (855) 774-7441 | www.healthequity.com

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Employee Assistance Program

PBSO 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 eight (8) visits with a specialist, per person, per issue, per year, 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 and Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or the Benefits Division), 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 | Customer Service: (888) 371-1125
www.myCigna.com | Access Code: pbso

Cigna EAP - Emergency Responders Support Line
Phone: (877) 505 3671 | www.myCigna.com | Employer ID: pbso

Long Term Disability

PBSO provides Long Term Disability (LTD) insurance at no cost to all eligible employees through New York Life Group Benefit Solutions. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or non-work related injury.

Long Term Disability (LTD) Benefits

- LTD provides a benefit of 60% of employee's monthly earnings up to a benefit maximum of $10,000 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.
- LTD benefits may be reduced by other income.
- LTD benefits may be taxable.

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

Public Safety Statutory Benefit

Public Safety employees (sworn personnel) are also covered, per Florida Statutes through The Hartford, in respect of the following hazards:

Hazard	Department	Benefit Payout *As of 10/1/2021*
Unlawful and Intentional Death	Sworn Personnel	$225,000
In Line of Duty	Sworn Personnel	$75,000
Fresh Pursuit*	Sworn Personnel	$75,000

**Includes Heart & Circulatory; Hypertension; or Tuberculosis, presuming the requirements of the Statutes are met.*

***Please contact the Benefits Division for up-to-date benefit amounts.*

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Basic Life and AD&D Insurance

Basic Term Life Insurance

PBSO provides Basic Term Life insurance at no cost to all eligible employees though New York Life Group Benefit Solutions. Eligible employees will receive a benefit amount equal to one (1) time employee's annual salary rounded to the next higher $1,000, up to a maximum of $250,000.

Accidental Death & Dismemberment Insurance (AD&D)

Also, at no cost to employee, PBSO 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 *(Basic Term Life Insurance)*

Benefit amounts are subject to the following age reduction schedule:

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

Life Insurance Imputed Income

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

Voluntary Life Insurance

Voluntary Employee Life Insurance

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

New Hires may purchase Voluntary Employee Life insurance without Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of the lesser, five (5) times employee's annual salary or $275,000.**

Voluntary Life Insurance *(Continued)*

Voluntary Employee Life Insurance *(Continued)*

- Coverage can be purchased in amounts of one (1), two (2), three (3), four (4) or five (5) times annual salary rounded to the next higher $1,000.
- Basic and Voluntary Life coverage combined may not exceed six (6) times annual salary or $1,000,000.
- Cost is $0.26 per $1,000 of coverage per month.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 45% of the benefit amount at age 70
  - Reduces to 30% of the benefit amount at age 75
  - Reduces to 20% of the benefit amount at age 80

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

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

- Employee may elect coverage in the amount of $50,000 for Voluntary Spouse/Domestic Partner Coverage.
- Employee may elect coverage in the amount of $500 for dependent child(ren) birth to age six (6) months.
- Employee may elect coverage in the amount of $25,000 for children age six (6) months to age 19 (age 26, if full-time student).
- Spouse/Domestic Partner and/or Dependent Child(ren) Life insurance coverage is $2.48 per pay period, whether Spouse/Domestic Partner or Dependent Child(ren) are covered together or separately.
- Spouse/Domestic Partner benefit amounts are subject to the following age reduction schedule based on spouse/domestic partner's age:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 45% of the benefit amount at age 70
  - Reduces to 30% of the benefit amount at age 75
  - Reduces to 20% of the benefit amount at age 80

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through the Benefits Division.

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

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Supplemental Insurance

Preferred Legal Plan

PBSO offers employees the opportunity to enroll in a voluntary pre-paid legal program through Preferred Legal Plan. By enrolling in this plan, a participant will have direct access to attorneys who will provide legal assistance 24 hours a day/7 days a week for a variety of situations such as those examples provided below. Additional services may also be provided at discounted rates.

Preferred Legal Plan service examples:

- ✓ Divorce
- ✓ Domestic Violence
- ✓ Civil Litigation
- ✓ Child Custody and Support
- ✓ Probate
- ✓ Immigration
- ✓ Wills *(Member and Spouse)*
- ✓ Real Estate

Legal Insurance – Preferred Legal Plan

Monthly Deductions

	Employee Cost
Employee Only	$11.45
Employee +One	$11.45
Employee + Family	$16.45

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

Identity Theft Protection

iDefend plan provides protection against all forms of identity theft. It is available to employee and family members, including children up to age 25. iDefend benefit includes the seven (7) essentials of whole identity protection:

- ✓ Whole Identity Monitoring
- ✓ Cyber Crime Protection
- ✓ Credit Protection
- ✓ Privacy Protection
- ✓ Lost Wallet Protection
- ✓ Whole Identity Recovery
- ✓ Cyberhood Watch Membership

Identity Theft Protections – iDefend

Monthly Deductions

	Employee Cost
Employee Only	$0.00
Employee + One	$9.95
Employee + Family	$12.95

iDefend | Customer Service: (801) 724-6211
Agent: Mark Brown | Phone: (561) 869-4495

Washington National

Washington National Insurance offers a variety of supplemental insurance plans that may be purchased separately on a voluntary basis. Premiums are paid via payroll deduction. Washington National pays cash directly to the employee, regardless of what other insurance plans employee may have. Coverage is available for employee, spouse and children on most plans. Coverage is portable when employee retires or changes jobs, with no increase in premiums. To learn more about these plans and to schedule a personal appointment, contact the local agent.

The following plans are available:

- ✓ Accidental Injury Insurance
- ✓ Cancer Insurance
- ✓ Critical Illness
- ✓ Active Care
- ✓ Return of Premium

Washington National
Claims : (800) 525-7662 | my.washingtonnational.com
Agent: Todd Louer | Phone: (954) 465-9535
Email: Todd.Louer@optavise.com
Agent: Liana Castellano | Phone: (702) 296-1022
Email: Liana.Castellano@optavise.com

PBSO Retirement

PBSO Retirement benefits and subsidy guidelines can be found in GO 316.00 and GO 208.03. It is the employee's responsibility to understand and adhere to all FRS and PBSO retirement guidelines.

FRS | Investment Plan: (866) 446-9377 | www.myfrs.com
Pension Plan: (844) 377-1888 | www.frs.myflorida.com
PBSO Retirement: (561) 688-3551 (Option 1, then Option 3)
retirement@PBSO.org

FRS Deferred Retirement Option Program

The FRS Deferred Retirement Option Program (DROP) allows employees to retire and begin accumulating retirement benefits without terminating employment for up to 96 months after the employee reaches normal retirement age. Employee will not earn additional service credit for retirement while in DROP. When the DROP period ends, employee must terminate all employment with FRS employer(s). At that time, employee will receive payment of the accumulated DROP benefits, and begin receiving monthly retirement benefits. FRS determines eligibility to participate in DROP. For more information contact the Benefits Division-Retirement Section at (561) 688-3551, Option 1; Then Option 3. Contact FRS to request a DROP calculations estimate. Employees may also access their DROP calculations by logging in to their account online at www.frs.fl.gov.

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Florida Retirement System

Florida Retirement System (FRS)

The Florida Retirement System is a state-administered retirement program for employees who are employed in regularly established positions. Employees may choose to participate in the FRS Pension Plan or the FRS Investment Plan. New hires are given eight months following the employee's month of hire to elect membership in the FRS Pension or investment plan. Effective January 1, 2018, new employees that do not make a plan election risk being defaulted into a plan in accordance with their membership class.

FRS Pension Plan

The FRS Pension Plan is a traditional, defined-benefit retirement plan. For employees hired prior to July 1, 2011, vesting occurs after six (6) years of service. For employees hired on or after July 1, 2011, vesting occurs after eight (8) years of service.

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 employee's account and how well that money grows over time when invested. Employees choose from several available payout options when the benefit is taken.

FRS Normal Retirement

Sworn or Certified *(Special Risk Class)*

Members enrolled in FRS prior to July 1, 2011

- 6 years of creditable service and age 55; or
- 25 years of Special Risk creditable service, regardless of age

Members enrolled on/after July 1, 2011

- 8 years of creditable service and age 55; or
- 25 years of Special Risk creditable service, regardless of age

Civilian *(Regular Class)*

Members enrolled in FRS prior to July 1, 2011

- 6 years of creditable service and age 62; or
- 30 years of creditable service, regardless of age

Members enrolled on/after July 1, 2011

- 8 years of creditable service and age 65; or
- 33 years of creditable service, regardless of age

FRS Early Retirement

If employee takes early retirement (at least eight (8) years of service but have not yet reached age 65 for civilians or age 55 for sworn), the amount of the retirement benefit will be reduced by 5% for each year, prior to normal retirement.

FRS Contribution Rate

The employee and employer are required by law to contribute a percentage of the employee's retirement eligible salary. The employee's contribution rate is 3%. For more information on the employer's contribution rate, visit www.frs.fl.gov.

Voluntary Deferred Compensation 457(b)

PBSO employees are eligible to enroll in a voluntary Deferred Compensation 457(b) Plan. Deferred Compensation permits employees to authorize a portion of their salary to be withheld and invested in one (1) or more of an array of investment options. Employees can make contributions on a pre-tax or after-tax Roth basis. On a pre-tax basis, neither the contributed amount nor any investment earnings are subject to current Federal State income taxes until the deferred income plus earnings are distributed to employees. These distributions are generally taken at retirement when employees may be in a lower income tax bracket.

On a Roth Plan, contributions are made on an after-tax income basis. Qualifying Roth distributions are tax-free income after age 59½ and after five (5) years of participation.

Employees maintain contributions through Lincoln Financial Group at www.lfg.com. To learn more about the Deferred Compensation 457(b) Plan and/or to schedule a personal appointment, contact Lincoln Financial Group.

Lincoln Financial Group
Customer Service: (800) 234-3500 | www.lfg.com

For general FRS or 457(b) Deferred Compensation questions, contact the Benefits Division, Retirement Section at (561) 688-3551, Option 1; Then Option 3

Heritage Financial Consultants

Need help organizing your finances, estate, or investment planning, or reaching your retirement goals? Think about using a financial advisor. Heritage Financial Consultants, LLC offers free financial planning consultations. Contact registered financial representative, Alejandro Jerez for more information. Your financial future is worth it.

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