ORANGE COUNTY FIREFIGHTERS'

HEALTH & WELFARE BENEFIT TRUST INC.

HEALTH • WELLNESS • FUTURE

EST. 2026

2027 | **PARTICIPANT BENEFIT HIGHLIGHTS**

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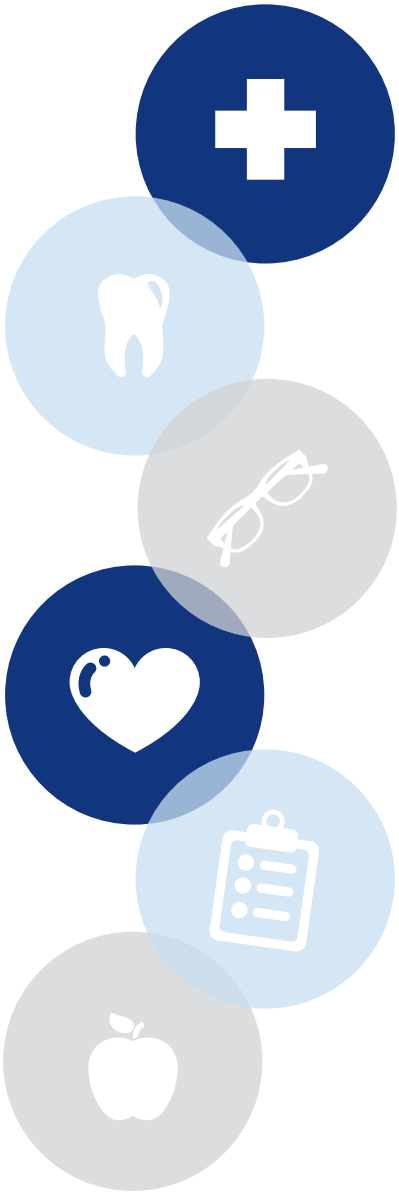

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OCFFHT reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

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Contact Information

	Trust Benefits Administrator	Crystal Flores Onsite Benefits Specialist	Phone: (407) 389-2057 Email: BenefitsAdmin@ocfirehealthtrust.org
	Online Benefit Enrollment	Bentek Support	Phone: (888) 5-Bentek (523-6835) Email: support@mybentek.com app.mybentek.com
	Medical Insurance	Cigna Healthcare	Phone: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage & Mail Order Program	Express Scripts Pharmacy through Cigna Healthcare	Phone: (800) 835-3784 www.mycigna.com
	Virtual Care	MDLIVE through Cigna	Phone: (888) 726-3171 www.mycigna.com
	Health Savings Account (HSA)	Cigna Healthcare	Phone: (800) 244-6224 www.mycigna.com
	Dental Insurance	Cigna Healthcare	Phone: (800) 244-6224 www.mycigna.com
	Vision Insurance	MetLife	Phone: (833) 393-5433 www.metlife.com
	Flexible Spending Accounts	P&A Group	Phone: (716) 852-2611 www.padmin.com
	Employee Assistance Program	Cigna Healthcare	Phone: (877) 622-4327 www.mycigna.com
	Fire Only Basic Life and AD&D Insurance	The Standard	Phone: (800) 628-8600 www.standard.com
	Voluntary Life and AD&D Insurance	The Standard	Phone: (800) 628-8600 www.standard.com
	Voluntary Short Term Disability Insurance	The Standard	Phone: (800) 368-2859 www.standard.com
	Claims, Billing & Benefit Assistance	Gehring Group	Phone: (800) 244-3696 Email: geh-ocffht@bbrown.com

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ORANGE COUNTY FIREFIGHTERS'
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Introduction

The OCFFHT provides group insurance benefits to eligible participants. The Participant Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the OCFFHT Certificates of Coverage for detailed descriptions of all available participant benefit programs and stipulations therein. If participant requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Trust Benefits Administrator.

Online Benefit Enrollment

OCFFHT offers participants convenient online benefits enrollment through Bentek®. Benefit eligible participants can enroll or make changes during the annual Open Enrollment period, New Hire Orientation, or following a Qualifying Life Event. Participants can log in to review detailed information about benefit plans, view current elections, and print summaries of coverage for themselves and dependents. Bentek also provides access 24 hours a day, year-round to important forms and carrier resources and enabling participants to update beneficiary designations.

Accessing Bentek

- ✓ Visit **app.mybentek.com**
- ✓ Sign in with email and password, or select "Create an Account."
- ✓ Need Password Help? Follow the link for a password reset.
- ✓ Once logged in, use the Launchpad icons to navigate.

Technical Support

For technical assistance related to using the platform, contact Bentek Support:
Email: support@mybentek.com
Phone: (888) 5-Bentek (523-6835)

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

Scan QR Code to Access Bentek
For the best experience, we recommend enrolling on a computer.



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Group Insurance Eligibility



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

Participant Eligibility

Participants are eligible to participate in OCFFHT's insurance plans if they are full-time participants working a minimum of 30 hours per week. Coverage will be effective date of hire.

Separation of Employment

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

Dependent Eligibility

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

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. An over-age dependent (taxable dependent) may continue to be covered on the medical plan to the end of the calendar year in which the child 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.

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

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

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

Disabled Dependents

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

- Is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Unmarried and primarily dependent upon the participant 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 Trust Benefits Administrator for more information.

Taxable Dependents

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

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

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Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

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

Under certain circumstances, participant may be allowed to make changes to benefit elections during the plan year if the event affects the participant, 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 participant, participant's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in participant'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 participant experiences a Qualifying Event, **Trust Benefits Administrator must be contacted within 30 days of the Qualifying Event** to make changes to participant's coverage. Participant 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 participant may be responsible, both legally and financially, for any claim and/or expense incurred as a result of participant 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 Plan(s) is provided as a supplement to this booklet being distributed to new hires and existing participants during the Open Enrollment Period. The summary is an important item in understanding participant's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	Trust Benefits Administrator
Address:	6969 Venture Circle Orlando, FL 32807
Phone:	(407) 389-2057
Website:	app.mybentek.com

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 by contacting Trust Benefits Administrator.

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Medical Insurance

OCFFHT offers medical insurance through Cigna Healthcare to benefit-eligible participants. 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 SureFit Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Participant Cost
Participant Only	$0.00
Participant + Spouse	$120.00
Participant + Child(ren)	$80.00
Participant + Family	$200.00

Medical Insurance – Cigna OAP Low Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Participant Cost
Participant Only	$34.00
Participant + Spouse	$176.00
Participant + Child(ren)	$142.00
Participant + Family	$300.00

Medical Insurance – Cigna OAP Plus HSA Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Participant Cost
Participant Only	$18.00
Participant + Spouse	$146.00
Participant + Child(ren)	$114.00
Participant + Family	$260.00

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

Opt Out Credit

Participants who waive OCFFHT's medical plan as a new hire, during annual Open Enrollment or as a result of a Qualifying Event will receive a credit of up to $25.00 per pay period in premium reduction dollars. These funds may only be used to offset the cost of the dental, vision, or Voluntary Employee Life plans. The credit cannot be used toward the cost of the Voluntary Spouse Life, Voluntary Dependent Child Life, or Voluntary Short Term Disability. If participant chooses no option, the benefit is forfeited. If the benefit is partially utilized, any unused credit dollars after enrollment will be forfeited. Please contact the Trust Benefits Administrator for additional information.

Virtual Care

Cigna Healthcare provides access to virtual care 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 care via phone and online video consultations when needing immediate care for non-emergency medical issues. MDLIVE should be considered when participant's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with virtual care.

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

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

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

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Medical Plan Resources

Enrolled participants 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.

Cigna Wellness Experience

The Cigna Wellness Experience is a voluntary program available at no additional cost to participants enrolled in one of OCFFHT's medical plans. The program supports participants in improving overall health and well-being through personalized goals, digital coaching, and healthy lifestyle activities. The program also offers four (4) reward levels for participants. Based on the number of points earned participants can earn up to $250 in Wellness Rewards by completing qualifying activities in the myCigna mobile app. An additional $450 can be earned for $700 total from the Wellness Activities and Action Rewards combined.

Complete Wellness Actions to Earn Rewards

Level	Rewards
Complete Health Assessment	Gatekeeper – Complete to unlock rewards
Complete Biometric Screening	$50
Complete Biometric Outcome	Up to $100
Complete Annual Physical	$200
Complete Preventive Care	Up to $300
Specific Chronic Claims*	Up to $200

**Customers identified with a chronic condition have additional opportunities not to exceed the overall incentive maximum.*

Please Note: *Participants must earn at least $500 in incentives to earn the PTO Wellness Day.*

Complete myCigna Wellness Activities to Earn Points for Rewards

Level	Points	Rewards
Level 1	7,000	$40
Level 2	25,000	+$60
Level 3	40,000	+$70
Level 4	60,000	+$80

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.

Cigna One Guide

Cigna One Guide service can help participants and dependents make smarter informed choices and get the most from the medical plan enrolled. One Guide personal support, tools and reminders can help participants 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.

Healthy Pregnancies, Healthy Babies

Healthy Pregnancies, Healthy Babies Program is designed to help mothers-to-be and baby stay healthy during pregnancy and in the days and weeks following baby's birth.

Log on to www.mycigna.com, select Wellness, then select Health Topics & Resources or call (800) 615-2906.

Omada Diabetes Prevention Program

Cigna has partnered with Omada Health who is the nation's leading CDC-recognized provider of the Diabetes Prevention Program (DPP). Through its DPP, Omada delivers cost- effective prevention services for populations at risk or in the early stages of developing type 2 diabetes and other chronic conditions. This program is at no additional cost to participants and adult dependents on the Cigna medical plan. Those who qualify will learn how to adapt healthier eating habits, increase activity and reduce the risks of type 2 diabetes and heart disease. To find out if participant qualifies for the OMADA program, please contact Cigna.

Cigna 90 Now

With Cigna 90-Now, participant has more choices in how and where to fill a prescription. This plan offers a new 90-day prescription retail pharmacy network. Participant can also elect to fill 90-day prescriptions with Cigna/Express Scripts Pharmacy where Cigna will deliver participant's medications at a location of the participant's choice. Standard shipping is free.

For more information about the Cigna 90-Now program, please contact customer service at (800) 285-4812 or www.mycigna.com.

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

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Cigna SureFit Plan At-A-Glance

Locate a Provider

To find a participating provider, contact customer service or visit www.mycign.com. When searching, select the SureFit Florida network.

Plan References

**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.*

Important Notes

*Services received by providers or facilities **not** in the SureFit Florida network, will not be covered.*

Network	SureFit Florida
Calendar Year Deductible (CYD)	**In-Network**
Individual	$1,500
Family	$3,000
Coinsurance	
Member Responsibility	20%
Calendar Year Out-of-Pocket Maximum	
Individual	$3,000
Family	$6,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$30 Copay + 20%
Specialist Office Visit	$50 Copay + 20%
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)**	20% After CYD
X-rays	20% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD
Outpatient Surgery at Surgical Center	20% After CYD
Physician Services at Surgical Center	20% After CYD
Urgent Care *(Per Visit)*	$50 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	20% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD
Physician Services at Hospital	20% After CYD
Emergency Room *(Per Visit)*	20% After CYD
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	20% After CYD
Outpatient Services *(Per Visit)*	20% After CYD
Outpatient Office Visit	$40 Copay
Prescription Drugs *(Rx)*	
Generic	$10
Preferred Brand Name	$30 After CYD
Non-Preferred Brand Name	$50 After CYD
Specialty Drug	10% + CYD
90-Day Supply *(Mail Order/Retail Pharmacy)*	$25 / $75 After CYD / $125 After CYD / 10% + CYD

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Cigna OAP Low Plan At-A-Glance

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Individual	$1,500	$3,000
Family	Individual: $1,500 / Family: $3,000	Individual: $3,000 / Family: $6,000
Coinsurance		
Member Responsibility	20%	50%
Calendar Year Out-of-Pocket Maximum		
Individual	$3,000	$6,000
Family	Individual: $3,000 / Family: $6,000	Individual: $6,000 / Family: $12,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$30 Copay	50% After CYD
Specialist Office Visit	$50 Copay	50% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	20% After CYD	50% After CYD
X-rays	20% After CYD	50% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD	50% After CYD
Outpatient Surgery at Surgical Center	20% After CYD	50% After CYD
Physician Services at Surgical Center	20% After CYD	50% After CYD
Urgent Care *(Per Visit)*	$40 Copay	$40 Copay
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After CYD	50% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD	50% After CYD
Physician Services at Hospital	20% After CYD	50% After CYD
Emergency Room *(Per Visit)*	20% After CYD	20% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	20% After CYD	50% After CYD
Outpatient Services *(Per Visit)*	0% After CYD	50% After CYD
Outpatient Office Visit	$50 Copay	50% After CYD
Prescription Drugs *(Rx)*		
Generic	$10 Copay	50% Coinsurance
Preferred Brand Name	10% Coinsurance	50% Coinsurance
Non-Preferred Brand Name	30% Coinsurance	50% Coinsurance
Specialty Drug	Based on Applicable Tiers	Based on Applicable Tiers
90-Day Supply *(Mail Order/Retail Pharmacy)*	$30 Copay / 10% Coinsurance / 30% Coinsurance	50% Coinsurance

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.*

***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.*

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Cigna Choice OAP Plus HSA 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.

***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	$1,750	$3,200
Family	$3,500	$6,400
Coinsurance		
Member Responsibility	20%	50%
Calendar Year Out-of-Pocket Maximum		
Individual	$3,000	$6,000
Family	$6,000	$12,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	20% After CYD	50% After CYD
Specialist Office Visit	20% After CYD	50% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	20% After CYD	50% After CYD
X-rays	20% After CYD	50% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD	50% After CYD
Outpatient Surgery at Surgical Center	20% After CYD	50% After CYD
Physician Services at Surgical Center	20% After CYD	50% After CYD
Urgent Care *(Per Visit)*	20% After CYD	20% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After CYD	50% After CYD
Outpatient Hospital *(Per Visit)*	20% After CYD	50% After CYD
Physician Services at Hospital	20% After CYD	50% After CYD
Emergency Room *(Per Visit)*	20% After CYD	20% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	20% After CYD	50% After CYD
Outpatient Services *(Per Visit)*	20% After CYD	50% After CYD
Outpatient Office Visit	20% After CYD	50% After CYD
Prescription Drugs *(Rx)*		
Generic	$10 Copay After CYD	50% After CYD
Preferred Brand Name	10% After CYD	50% After CYD
Non-Preferred Brand Name	30% After CYD	50% After CYD
Specialty Drug	Based on Applicable Tiers	Based on Applicable Tiers
90-Day Supply *(Mail Order/Retail Pharmacy)*	$30 Copay After CYD / 10% After CYD / 30% After CYD	50% After CYD

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Health Savings Account (HSA)

The Cigna Choice Fund OAP Plus 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 participant and eligible dependent(s) deductible, coinsurance and any qualified health care expenses not covered by the plan.

Plan Year Funding

OCFFHT HSA Funding Allotment for 2027:

- **Individual: $1,000**
- **Family: $1,550**
- **HSA amounts will be prorated based on date of eligibility outside of OCFFHT's annual Open Enrollment Period.**

OCFFHT funding will be distributed via evenly dispersed payroll deductions, not as a lump sum. Participant may opt to fund an HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction. Participant contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on participant's tax return (making such contributions tax-free).

- 2026 IRS Contribution Limitations: $4,400 (individual coverage) $8,750 (family coverage)
- 2027 IRS Contribution Limitations: $4,500 (individual coverage) $9,000 (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 OCFFHT and participant contributions (pre-tax or post-tax). If participant is receiving an OCFFHT contribution, participant 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 Trust Benefits Administrator for further information regarding funding variations towards employer HSA contributions.*

What to Know About an HSA

- To be eligible to open an HSA, participant must be covered by a qualified high deductible health plan. Participant may not be covered under another medical plan that is not a high deductible health plan including a plan the participant's spouse may have selected where they have family coverage. Eligibility status to qualify for an HSA is specifically driven by participant and NOT dependents.
- Participant 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.
- HSA funds may earn interest.
- If the HSA is funded with OCFFHT contributions, participant 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.
- Balance, activity and account history are available on the online portal or by contacting customer service.
- HSA funds are portable from one employer to another. Accumulated funds can help participant plan for retirement.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the participant's group insurance benefits as long as the dependent is a qualified tax dependent.
- Participant'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 participant is enrolled in Medicare, TRICARE or TRICARE for Life, participant is not eligible to contribute funds into an HSA. In addition, the IRS prohibits an employer from contributing HSA funds into the account. If participant is not enrolled in Medicare, TRICARE or TRICARE for Life, then participant is eligible to enroll and contribute into the HSA up to the maximum contribution amounts of tier enrolled.
- Active participant NOT on Medicare but with a spouse enrolled in Medicare: An active participant 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 participant and spouse expenses.
- Active participant ON Medicare and with a spouse NOT enrolled in Medicare: An active participant 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.

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

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Dental Insurance

Cigna Dental PPO Low Plan

OCFFHT offers dental insurance through Cigna Healthcare to benefit-eligible participants. 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 Dental PPO Low Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Participant Cost
Participant Only	$10.68
Participant + One Dependent	$21.18
Participant + Two or More Dependents	$46.23

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 dentist 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 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 Dental PPO Low plan requires a $50 individual or a $150 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 Dental PPO Low 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.

Cigna Dental Wellness*Plus*®

Cigna Dental Wellness*Plus*® rewards members and covered dependents for getting preventive dental care. When members visit a dentist for preventive care, the Calendar Year Benefit Maximum towards covered Class II or Class III services will increase $250 for each year the member and covered dependents continue to receive preventive care.

Preventive Benefit Applies	Calendar Year Maximum
Level 1	$1,000
Level 2	$1,250
Level 3	$1,500
Level 4	$1,750

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

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Cigna Dental PPO Low Plan At-A-Glance

Network	Total	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,000	
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 Sets Per Calendar Year)*		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 60% After CYD	Plan Pays: 60% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Oral Surgery		
Endodontics *(Root Canal Therapy)*		
Anesthetics		
Class III Services: Major Restorative Care		
Periodontal Services	Plan Pays: 30% After CYD	Plan Pays: 30% After CYD *(Subject to Balance Billing)*
Crowns		
Bridges		
Dentures		
Class IV Services: Orthodontia		
Benefit	Not Covered	Not Covered
Class IX Services: Implants		
Benefit	Not Covered	Not Covered

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 out-of-network providers, 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 participant have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

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Dental Insurance

Cigna Dental PPO Mid Plan

OCFFHT offers dental insurance through Cigna Healthcare to benefit-eligible participants. 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 PPO Mid Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Participant Cost
Participant Only	$11.42
Participant + One Dependent	$22.88
Participant + Two or More Dependents	$52.18

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 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 dentist 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 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 Dental PPO Mid plan requires a $50 individual or a $150 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 Dental PPO Mid plan will pay for each covered member is $1,000 for in-network or $750 for out-of-network services. 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.

Cigna Dental Wellness*Plus*®

Cigna Dental Wellness*Plus*® rewards members and covered dependents for getting preventive dental care. When members visit a dentist for preventive care, the Calendar Year Benefit Maximum towards covered Class II or Class III services will increase $250 for each year the member and covered dependents continue to receive preventive care.

Preventive Benefit Applies	Calendar Year Maximum *(In-Network)*	Calendar Year Maximum *(Out-of-Network)*
Level 1	$1,000	$750
Level 2	$1,250	$1,000
Level 3	$1,500	$1,250
Level 4	$1,750	$1,500

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

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Cigna Dental PPO Mid Plan At-A-Glance

Network	Total	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,000	$750
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 Sets Per Calendar Year)*		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 70% After CYD	Plan Pays: 70% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Oral Surgery		
Endodontics *(Root Canal Therapy)*		
Anesthetics		
Class III Services: Major Restorative Care		
Periodontal Services	Plan Pays: 40% After CYD	Plan Pays: 40% After CYD *(Subject to Balance Billing)*
Crowns		
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Dependent Children up to Age 19)*	Plan Pays: 40%	Plan Pays: 40% *(Subject to Balance Billing)*
Class IX Services: Implants		
Benefit	Plan Pays: 40% After CYD	Plan Pays: 40% After CYD *(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 out-of-network providers, 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 participant have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

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Dental Insurance

Cigna Dental PPO High Plan

OCFFHT offers dental insurance through Cigna Healthcare to benefit-eligible participants. 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 Dental PPO High Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Participant Cost
Participant Only	$15.87
Participant + One Dependent	$31.55
Participant + Two or More Dependents	$68.52

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 dentist 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 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 Dental PPO High plan requires a $50 individual or a $150 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 Dental PPO High plan will pay for each covered member is $1,500 for in-network or $1,250 for out-of-network services. 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.

Cigna Dental Wellness*Plus*®

Cigna Dental Wellness*Plus*® rewards members and covered dependents for getting preventive dental care. When members visit a dentist for preventive care, the Calendar Year Benefit Maximum towards covered Class II or Class III services will increase $250 for each year the member and covered dependents continue to receive preventive care.

Preventive Benefit Applies	Calendar Year Maximum *(In-Network)*	Calendar Year Maximum *(Out-of-Network)*
Level 1	$1,500	$1,250
Level 2	$1,750	$1,500
Level 3	$2,000	$1,750
Level 4	$2,250	$2,000

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

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Cigna Dental PPO High Plan At-A-Glance

Network	Total	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$1,500	$1,250
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 Sets 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		
Endodontics (Root Canal Therapy)		
Anesthetics		
Class III Services: Major Restorative Care		
Periodontal Services	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Crowns		
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Adult and Children)*	Plan Pays: 50%	Plan Pays: 50% *(Subject to Balance Billing)*
Class IX Services: Implants		
Benefit	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(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 out-of-network providers, 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 participant 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

MetLife Vision Plan

OCFFHT offers vision insurance through MetLife to benefit-eligible participants. 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 – MetLife Vision Plan

26 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Participant Cost
Participant Only	$3.02
Participant + One Dependent	$5.88
Participant + Family	$10.45

In-Network Benefits

The vision plan offers participant and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, participant and covered dependent(s) may select any network provider who participates in the MetLife Superior 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

Participant and covered dependent(s) may choose to receive services from vision providers who do not participate in the MetLife Superior Vision network. When going out of network, the provider will require payment at the time of appointment. MetLife 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.

MetLife
Phone: (833) 393-5433 | www.metlife.com

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MetLife Vision Plan At-A-Glance

Network		Superior Network	
Services		**In-Network**	**Out-of-Network**
Eye Exam		$5 Copay	Up to $45 Reimbursement
Contact Lens Exam *(Fit and Follow-Up)*	Standard Lens	$25 Copay	Applies to OON Contact Lens Reimbursement
	Premium	Up to $50 Allowance After $25 Copay	Applies to OON Contact Lens Reimbursement
Materials		$15 Copay	Reimbursement Based of Type of Service
Retinal Imaging		Up to $39 Copay	Applies to OON Eye Exam
Frequency of Services			
Examination		12 Months	
Lenses		12 Months	
Frames		24 Months	
Contact Lenses		12 Months	
Lenses			
Single		$15 Copay	Up to $30 Reimbursement
Bifocal		$15 Copay	Up to $50 Reimbursement
Trifocal		$15 Copay	Up to $65 Reimbursement
Frames			
Allowance		Up to $175 Allowance 20% Off Balance Over $175	Up to $70 Reimbursement
Contact Lenses*			
Non-Elective *(Medically Necessary)*		No Charge	Up to $210 Reimbursement
Elective	Conventional	Up to $175 Allowance 20% Off Balance Over $175	Up to $105 Reimbursement
	Disposable	Up to $175 Allowance 10% Off Balance Over $175	Up to $105 Reimbursement

Locate a Provider

To find a participating provider, contact customer service or visit www.metlife.com. When searching, select the Superior Vision 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

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

If participant or family member(s) has predictable health care or work-related day care expenses, then participant may benefit from participating in an FSA. An FSA allows participant to set aside money from participant'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 participant's paycheck and deposited into the FSA. During the year, participant 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 participant 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 $3,400. 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 participant can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Listed below are examples of common expenses that qualify for reimbursement.

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 $7,500 if single or married and file a joint tax return ($3,750 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

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

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

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

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

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests
- ✓ Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction
- ✓ 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

Log on to 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

- A 2.5 month grace period allows additional time to incur claims and use remaining funds on eligible expenses after the plan year ends.
- A 90 day run out period allows reimbursement of eligible expenses incurred during the plan year and/or grace period.
- 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.
- Funds cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Only expenses for services received are eligible for reimbursement.
- Reimbursed expenses cannot be covered by insurance or other compensation.
- Domestic partners' healthcare expenses are ineligible as they are not qualified dependents under Federal law.

Filing a Claim

Claim Form

Submit a completed claim form with a receipt 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. The 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, however, a small fee may apply.

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 participant earning $50,000 elects to place $1,000 annually into a Health Care FSA. The payroll deduction is $83.33 based on a monthly pay schedule. As a result, health care expenses are paid with tax-free dollars, giving the participant a tax savings of $197.

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

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

Claims Submission
Mail: 6400 Main Street, Suite 210, Williamsville, NY 14221
Fax: (877) 855-7105

The P&A Group
Phone: (716) 852-2611 | www.padmin.com

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Employee Assistance Program

OCFFHT cares about the well-being of all participants on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Cigna Healthcare. EAP offers participant 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 participant 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 participants 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 participant or family member's well-being. Coverage includes six (6) 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 & Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential.

To Access Services

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

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

Fire Only Basic Life and AD&D Insurance

Fire Only Basic Term Life Insurance

OCFFHT provides Basic Term Life insurance at no cost through The Standard for eligible participants with a benefit amount of $10,000.

Accidental Death & Dismemberment Insurance (AD&D)

Accidental Death & Dismemberment (AD&D) insurance, will pay in addition and equal to the Basic Term Life benefit when death occurs as a result of an accident. 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 50% of the benefit amount at age 70
- › Reduces to 35% of the benefit amount at age 75

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.

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek/Trust Benefits Administrator.

The Standard
Phone: (800) 628-8600 | www.standard.com

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Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

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

2027 Open Enrollment: Eligible participants 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 $200,000.

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 $200,000.**

- Units can be purchased in increments of $10,000 to the maximum of $300,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70
  - Reduces to 35% of the benefit amount at age 75

Voluntary Life and AD&D Insurance Rate Table

Monthly Premium

Age Bracket	Employee/Spouse *(Rate Per $1,000 of Benefit)*
Under 30	$0.05
30-34	$0.07
35-39	$0.11
40-44	$0.12
45-49	$0.17
50-54	$0.25
55-59	$0.45
60-64	$0.63
65-69	$1.29
70+	$2.08

Voluntary Spouse Life and AD&D Insurance

2027 Open Enrollment: Eligible spouses 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 $50,000.

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 $50,000.**

- Participant must participate in the Voluntary Employee Life and AD&D plan for spouse to participate.
- Units can be purchased in increments of $10,000 to a maximum of $250,000 not to exceed 100% of the participant's Fire Only Basic Term Life and Voluntary Life combined coverage amount.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70
  - Reduces to 35% of the benefit amount at age 75
  - Age reductions are based on spouse age.

Voluntary Dependent Child(ren) Life Insurance

- Participant must participate in Voluntary Employee Life plan for dependent child(ren) to participate.
- Coverage may be purchased for dependent child(ren) birth up to the date on which the dependent child reaches age 26 in increments of $5,000 to a maximum of $10,000.
- Monthly cost for Voluntary Dependent Child(ren) Life coverage elected is $0.06 per $1,000 for each eligible dependent child(ren) enrolled.

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek/Trust Benefits Administrator.

The Standard
Phone: (800) 628-8600 | www.standard.com

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Voluntary Short Term Disability

OCFFHT offers Voluntary Short Term Disability (STD) insurance to all eligible participants through The Standard. The STD benefit pays participant a percentage of weekly earnings if participant becomes disabled due to an illness or non-work related injury.

Voluntary Short Term Disability (STD) Benefits

- STD provides a benefit of 60% of participant's weekly earnings up to a benefit maximum of $2,500 per week.
- Participant must be disabled for a specified period prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin after the elimination period of their selected STD plan, as outlined on the table below.
- Participant deemed unable to return to work after the STD maximum period is exhausted, may be transitioned to Long Term Disability (LTD).
- Benefits may be reduced by other income and may be taxable.

Plan Option	Monthly Premium *(Rate per $10 of weekly benefit)*	Elimination Period	Benefit Period
Plan Option 1	$0.08	120 Days	60 Days
Plan Option 2	$0.12	90 Days	90 Days
Plan Option 3	$0.21	60 Days	120 Days
Plan Option 4	$0.27	30 Days	150 Days
Plan Option 5	$0.31	15 Days	165 Days

The Standard
Phone: (800) 628-8600 | www.standard.com

Claims, Billing & Benefit Assistance

If participants have questions on claims, receive bills from providers which they do not understand or would like general information on any of the participant benefits provided, please contact the Gehring Group Service Team.

The Service Team works directly with OCFFHT and its participants to provide claims and benefits service and will assist participants with their concerns. Please remember this is in addition to the OCFFHT's Trust Benefits Administrator and is not replacing assistance participant may need from Trust Benefits Administrator.

Contact a Claims Specialist

Email: geh-ocffht@bbrown.com

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

OR

Phone: (800) 244-3696

When calling, please identify yourself as a participant of the OCFFHT and ask to speak to a Claims Specialist or another member of the OCFFHT's designated team to assist with questions or concerns.

Office hours are Monday through Friday, 8:30 am - 5:00 pm (EST). If calling after office hours, please leave a message indicating you are a OCFFHT participant who would like to speak to a Claims Specialist. Please leave full name, contact information and a brief message and a Claims Specialist will be in contact with you the following business day.

Our goal is to be your advocate and ensure issues are resolved as quickly as possible.

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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.

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ORANGE COUNTY FIREFIGHTERS'

HEALTH & WELFARE BENEFIT TRUST INC.

HEALTH • WELLNESS • FUTURE

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GEHRING GROUP

BROWN & BROWN PUBLIC SECTOR

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This document is designed to provide basic information regarding benefit plans and programs available to eligible participants. This document merely summarizes the participant benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former participant, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any participant benefit plan or program. Your employer reserves the right to amend or terminate any of its participant benefit plans and programs at any time and without notice or cause.