



NORTH MIAMI

FLORIDA



2016 EMPLOYEE BENEFITS

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Benefit Resource Directory

PERSONNEL DEPARTMENT - CITY OF NORTH MIAMI

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 Personnel Administration Department
 Telephone: 1 (305) 893-6511 Ext. 12151
 Fax: 1 (305) 891-9375
 E-mail: bfriedman@northmiamifl.gov

SAPOZNIK INSURANCE

Andrew Goodman, Vice President
 E-mail: andrewg@sapoznik.com

Haydee Millan-Feliz, Account Manager
 E-mail: haydeem@sapoznik.com
 Telephone: 1 (877) 948-8887 | Fax: 1 (305) 949-1099
www.sapoznik.com

HEALTH INSURANCE

United Healthcare
 Telephone: 1 (800) 825-8792
www.myuhc.com

Neighborhood Health Partnership
 Telephone: 1 (877) 972-8845
www.mynhp.com

DENTAL INSURANCE

United Healthcare
 DHMO PLAN 1 (800) 955-4137
 PPO PLAN 1 (877) 816-3596
www.myuhcdental.com

VISION INSURANCE

United Healthcare
 Telephone: 1 (800) 638-3120
www.myuhcvision.com

LEGAL SERVICES

Legal Shield
 Telephone: 1 (800) 654-7757
www.LegalShield.com

Representative: Mitchell Summer
summerbenefitsgroup@gmail.com

SUPPLEMENTAL INSURANCE

AFLAC
 Telephone: 1 (800) 992-3522

Shelly Thompson
 Telephone: 1 (561) 340-1473
www.aflac.com

LIFE AD&D & DISABILITY INSURANCE

Lincoln Financial
 Telephone: 1 (800) 423-2765
www.lfg.com

EMPLOYEE ASSISTANCE PROGRAM

Lincoln Financial
www.lfg.com

EMPLOYEE CONNECT
 1 (888) 628-4824

LIFEKEYS
 1 (855) 891-3684

TRAVEL CONNECT
 1 (800) 527-0218

BENEFIT PLAN YEAR JANUARY 1 THROUGH DECEMBER 31, 2016

PLEASE NOTE: This Benefit Highlight Booklet is solely intended as a high-level overview and general reference guide on your employee benefits. This booklet is NOT your Summary of Benefits and Coverage (SBC) document required by the Affordable Care Act of 2010. As an enrollee, your actual SBC will be provided under separate cover, by your health carrier.

Health Insurance - HMO

www.mynhp.com | 1 (877) 972-8845
www.myuhc.com | 1 (800) 825-8792



	NHP HMO OA F0S4-M3 Plan	UHC CHOICE AHQ6-M1 PLAN
Physician	\$15 CO-PAY	\$15 CO-PAY
Specialist	\$25 CO-PAY	\$30 CO-PAY
Adult & Child Wellness / Adult Wellness Max	COVERED 100% (NO MAX)	COVERED 100% (NO MAX)
Mammograms	COVERED 100%	COVERED 100%
Emergency Room - Waived if Admitted	\$250 CO-PAY	\$150 CO-PAY
Urgent Care	\$35 CO-PAY	\$35 CO-PAY
Independent Clinical Lab	COVERED 100%	COVERED 100%
Diagnostic Testing / MRI, CAT Scans	\$200 CO-PAY	\$250 CO-PAY
Outpatient Surgery - Ambulatory Surgical Ctr	DED THEN 100%	DED THEN 100%
Provider Services Ambulatory Surgery Ctr (ASC)	DED THEN 100%	DED THEN 100%
Outpatient Surgery - Hospital	DED THEN 100%	DED THEN 100%
Inpatient Hospital	DED & \$500 PER ADMISSION	DED THEN 100%
Provider Services Hospital	DED THEN 100%	DED THEN 100%
Home Health	DED THEN 100% 60 VISITS	DED THEN 100% 60 VISITS
Outpatient Therapy	COVERED 100% 20 VISITS	\$15 CO-PAY 20 VISITS
Deductible	\$250/\$500	\$2,000/\$4,000
Deductible Included in Out of Pocket Max	YES	YES
Co-Insurance	100%	100%
Vision	Vision Screening (children through age 21) No co-pay when performed by PCP during routine wellness exam. Limited to services necessary to determine need for vision correction and to one exam per calendar year. No Adult Coverage.	Benefits are limited to 1 exam every 2 years. 100% after a \$15 co-payment (PCP or Optometrist)
Maximum Out of Pocket	\$3,000/\$6,000	\$3,000/\$6,000
Out of Pocket Includes	DED, CO-PAY, CO-INS & RX	DED, CO-PAY, CO-INS & RX
Prescription	\$10/\$35/\$50 SMCS: \$10/\$125/\$250	\$10/\$30/\$70
Lifetime Maximum	UNLIMITED	UNLIMITED
WEEKLY PAYROLL DEDUCTIONS	NHP HMO OA F0S4-M3 Plan	UHC CHOICE AHQ6-M1 PLAN
Employee Only	\$10.00	\$67.55
Employee + Spouse	\$128.53	\$251.69
Employee + Child(ren) Only	\$109.05	\$223.87
Employee + Family	\$223.27	\$396.91

The City does not reimburse 50% of deductible for United Healthcare.

SPECIAL NOTE: The above is just a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.

Health Insurance - POS

United Healthcare | www.myuhc.com | 1 (800) 825-8792



	UHC CHOICE PLUS AHRR-M1	
	IN-NETWORK	OUT-NETWORK
Physician	\$15 CO-PAY	DED & 70%
Specialist	\$30 CO-PAY	DED & 70%
Adult & Child Wellness Adult Wellness Max	COVERED 100% (NO MAX)	Adult: Not Covered Child: DED & 70%
Mammograms	COVERED 100%	DED & 70%
Emergency Room - Waived if Admitted	\$150 CO-PAY	
Urgent Care	\$35 CO-PAY	DED & 70%
Independent Clinical Lab	COVERED 100%	Prev: Not Covered All Other Labs: DED & 70%
Diagnostic Testing / MRI, CAT Scans	\$250 CO-PAY	DED & 70%
Outpatient Surgery - Ambulatory Surgical Center	DED & \$250 CO-PAY	DED & 70%
Provider Services Ambulatory Surgery Center (ASC)	DED THEN 100%	DED & 70%
Outpatient Surgery - Hospital	DED & \$250 CO-PAY	DED & 70%
Inpatient Hospital	DED & \$500 CO-PAY	DED & 70%
Provider Services Hospital	DED THEN 100%	DED & 70%
Home Health	DED THEN 100% 60 VISITS	DED & 70% 60 VISITS
Outpatient Therapy	\$15 CO-PAY 20 VISITS	DED & 70% 20 VISITS
Deductible	\$1,500/\$3,000	\$2,500/\$5,000
Deductible Included in Out of Pocket Max	YES	
Co-Insurance	100%	70%
Maximum Out of Pocket	\$2,000/\$4,000	\$5,000/\$10,000
Out of Pocket Includes	DED, CO-PAY, CO-INS & RX	DED & CO-INS
Prescription	\$10/\$30/\$50	
Lifetime Maximum	UNLIMITED	
WEEKLY PAYROLL DEDUCTIONS		
	UHC CHOICE PLUS AHRR-M1	
Employee Only	\$143.95	
Employee + Spouse	\$415.19	
Employee + Child(ren) Only	\$376.29	
Employee + Family	\$627.41	

SPECIAL NOTE: The above is just a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.

Health Insurance - POS (Retiree - Out of Area Only)

United Healthcare | www.myuhc.com | 1 (800) 825-8792



	UHC Choice Plus AHLP-M1	
	IN-NETWORK	OUT-NETWORK
Physician	\$15 CO-PAY	DED & 70%
Specialist	\$15 CO-PAY	DED & 70%
Adult & Child Wellness Adult Wellness Max	COVERED 100% (NO MAX)	Adult: Not Covered Child: DED & 70%
Mammograms	COVERED 100%	DED & 70%
Emergency Room - Waived if Admitted	\$100 CO-PAY	
Urgent Care	\$50 CO-PAY	DED & 70%
Independent Clinical Lab	COVERED 100%	Prev: Not Covered All Other Labs: DED & 70%
Diagnostic Testing / MRI, CAT Scans	DED & 90%	DED & 70%
Outpatient Surgery - Ambulatory Surgical Center	DED & 90%	DED & 70%
Provider Services Ambulatory Surgery Center (ASC)	DED & 90%	DED & 70%
Outpatient Surgery - Hospital	DED & 90%	DED & 70%
Inpatient Hospital	DED & 90%	DED & 70%
Provider Services Hospital	DED & 90%	DED & 70%
Home Health	DED & 90% 60 VISITS	DED & 70% 60 VISITS
Outpatient Therapy	\$15 CO-PAY 20 VISITS	DED & 70% 20 VISITS
Deductible	\$250/\$500	\$500/\$1,000
Deductible Included in Out of Pocket Max	YES	
Co-Insurance	90%	70%
Maximum Out of Pocket	\$2,250/\$4,500	\$4,500/\$9,000
Out of Pocket Includes	DED, CO-PAY, CO-INS & RX	
Prescription	\$10/\$30/\$50	
Lifetime Maximum	UNLIMITED	

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Try the OptumRx® Mail Service Pharmacy – you may save money, and it's convenient

If you are prescribed certain maintenance medications, you have the opportunity to maximize your savings by participating in your prescription drug mail order program.

Your Plans allow you to receive a 3 month's supply of an allowed maintenance medication at home by mail at a reduced co-pay.

Additional information including claim forms and mailing envelopes for the prescription envelopes for the prescription mail order program may be obtained by contacting Human Resources Department or by visiting: www.optumrx.com



NHP: 1-877-972-8845

UHC: 1-855-842-6337



Neighborhood Health Partnership uses OptumRx for certain pharmacy benefit services. You have access to a suite of online tools and information to help you get the most from your pharmacy benefit.

All you have to do is log on to [OptumRx](http://www.optumrx.com) to:

- Find prescription drug costs
- Search for lower-cost alternative medications
- Order maintenance medications through mail order
- View your prescription claims history
- Locate a pharmacy

To set up Mail Service, follow these simple steps

Step 1 Talk to your doctor

Get the right prescription

Request up to a 3-month supply, with refills for up to one year (if appropriate).

Step 2 Send your information to the mail service pharmacy



By phone:

- Call the member phone number on the back of your health plan ID card to get started



Online:

- Log on to myuhc.com
- Click on "Manage my Prescriptions"



By fax or electronically:

- Your doctor can call **1-800-788-4863** for instructions to fax prescription(s) directly to the OptumRx Mail Service Pharmacy (NOTE: Faxed prescriptions can only be accepted from your doctor's office)
- Ask your doctor to send immediately by using ePrescribe.



By mail:

- Ask your doctor for a new prescription for up to a 3-month supply, plus refills for up to one year (if appropriate)
- Go to myuhc.com and download an order form
- Mail the new prescription and order form¹ to the address provided.

STOP PAYING TOO MUCH FOR YOUR PRESCRIPTIONS

GoodRx

Compare prices, print free coupons & SAVE UP TO 80% TODAY



Download the App for savings on the go!



1. Go to www.goodrx.com
2. Enter Drug Name and Zip code
3. Compare prices from local pharmacies
4. Use Retail/Coupon savings if less expensive than current Pharmacy Plan.

Rx Pharmacy Convenience Starts Here



Having access to a discount prescription program can be an enormous benefit to anyone who has a chronic condition. When you have to buy the same medications regularly, it makes a huge difference to save as much money as possible each and every time. A discount prescription plan can help lower the prohibitive costs of these items.

You no longer need to search far and wide for discount prescription programs that offer genuine savings.

Pharmacy	Generic Rx Programs	Site
PUBLIX	Antibiotics Free Check with Publix on Selections	www.publix.com/pharmacy
RITE AID	\$9.99 / 30 Day Supply \$15.99 / 90 Day Supply	www.riteaid.com
K-MART	\$5 / 30 Day Supply \$10 / 90 Day Supply	www.kmart.com/pharmacy
TARGET	\$4 / 30 Day Supply \$10 / 90 Day Supply	www.target.com/pharmacy
Walmart Save money. Live better.	\$4 / 30 Day Supply \$10 / 90 Day Supply	www.walmart.com/pharmacy
CVS/pharmacy Expect something extra.	\$11.99 / 90 Day Supply	www.cvs.com/pharmacy

We encourage you to use local Pharmacy Discount programs available through your local pharmacy.

When you do, it's important to remind the pharmacist NOT to process your prescription through your medical plan.



What can I do at myuhc.com® ?

- Find a doctor.
- Track my blood pressure.
- Find a great hospital.
- Track my weight.
- Look up my claims.
- Improve my health.
- Order my prescriptions online – and save.
- Chat with a nurse.
- Simplify my life.
- Learn about diabetes.
- Save money on services.
- Stay healthy.
- Replace my health plan ID card.
- Record my health history.
- Keep track of my family's medical history.**
- Estimate costs ahead of time.
- Embrace wellness.
- See my benefits.
- Keep track of my shots.
- And much, much more.**



It's easy to register.

1. Visit www.myuhc.com
2. Select REGISTER NOW
3. Type in the requested information
4. Get started

Get more from your health benefits with myuhc.com

Organize my claims

- See the status of my current claims
- Check my past claims history
- View my monthly statements
- See my whole family in one view
- Print copies for my records

Find a doctor

- Search for a doctor or hospital in my area
- See which doctors meet stringent quality standards
- **Evaluate hospitals on cost, quality and patient safety**
- Find a mental health professional
- Get driving directions and print a map
- Find a doctor who treats a lot of people like me

Get the facts

- Learn more about my coverage
- Check my current eligibility
- Look up my deductible or out-of-pocket limit

Improve my health

- Take a complimentary online Health Assessment, with recommendations for change
- Read the most up-to-date, trustworthy healthy lifestyle advice
- Use tools, quizzes, and calculators on everything from aging well to world travel

UnitedHealthcare Health4MeSM Mobile App

- **Access your family's health information** anytime, anywhere.
- Features include easy access to registered nurses, personal health benefits information, and the ability to locate nearby physicians and hospitals (Currently available for iPhone® and Android™ operating systems.)

Get help with decisions

- **Learn more about health conditions or procedures**
- Connect with a nurse through live, one-to-one online Nurse Chats
- Check the facts on medications and estimate my costs
- Read up on common symptoms and what they might mean
- Explore various treatment options



mynhp.com

Neighborhood Health Partnership's mynhp.com is an Internet-based solution designed to enhance the existing NHP website with features that you can access at your convenience.

EASY

The mynhp.com website was designed to be easy to use. The website includes menus, buttons, tabs, and links to let you access our new features with a click of the mouse. Many of the web pages have mouseover instructions and prompts to help you.

USEFUL

The mynhp.com features allow you to:

- Review Benefits & Eligibility
- Search for participating providers
- Make PCP changes
- Request health plan ID cards
- Check referral/authorization status
- View claims status

SECURE

Neighborhood Health Partnership uses 128-bit encryption technology for mynhp.com and follows a privacy policy to protect its members' Personal Health Information. The Member portion of mynhp.com is password-protected and requires you to log-in with a unique user ID and password of your choice. You are free to change your password at any time.

SUPPORT

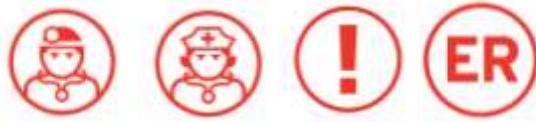
Help is available for any questions you may have. Our Member Representatives are available to answer questions at 1-877-972-8845, Monday-Friday, 8 a.m. to 6 p.m.

GETTING STARTED

Go to www.mynhp.com and click on the member link to register for a web account.

Have your NHP health plan ID card handy to complete registration process.

SPECIAL NOTE: The above is just a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.



Where should I go for care?

Helping you choose the right care center

Doctor's Office

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide preventive and routine care, manage your medications and refer you to a specialist, if necessary

Go to the Doctor's Office for:

- ◆ Routine checkups
- ◆ Immunizations
- ◆ Preventive services
- ◆ Manage your general health

Convenience Care Clinic

You can't get to your doctor's office, but your condition is not urgent or an emergency. Convenience care clinics are often located in malls or retail stores offering services for minor health conditions. Staffed by nurse practitioners and physician assistants.

Convenience Care Clinic can help with:

- ◆ Common infections (e.g., strep throat)
- ◆ Minor skin conditions (e.g., poison ivy)
- ◆ Flu shots
- ◆ Physicals
- ◆ Minor cuts
- ◆ Ear aches

Urgent Care

Sometimes, you may need care fast. But, your Primary Care Physician may be unavailable. You may want to try an urgent care center. They can treat many minor ailments. Chances are you **won't have to wait as long as at the ER.** You may pay less, too.

An Urgent Care Center can help with:

- ◆ Sprains
- ◆ Strains
- ◆ Minor broken bones (example: finger)
- ◆ Minor infections
- ◆ Small cuts
- ◆ Sore throats
- ◆ Rashes
- ◆ Colds

Hospital Emergency Room

You may be tempted to go to the emergency room (ER). But, this may not be the best choice. At the ER, true emergencies are treated first. Other cases must wait - sometimes for hours. And, it may cost you more.

Go to the ER for:

- ◆ Heavy bleeding
- ◆ Large open wounds
- ◆ Sudden change in vision
- ◆ Chest pain
- ◆ Sudden weakness or trouble talking
- ◆ Major burns
- ◆ Spinal injuries
- ◆ Severe head injury
- ◆ Difficulty breathing
- ◆ Major broken bones

When to use...

Hospital vs. Freestanding Facility

Diagnostic imaging can be expensive. With many health plans, you could save on out-of-pocket costs by having the study done at a freestanding facility.

In addition to standard X-rays, diagnostic imaging studies include:

Computed tomography (CT) scan, also called CAT scan

Magnetic resonance imaging (MRI)

Magnetic resonance angiography (MRA)

Bone mineral density (BMD) or bone density scan

Ultrasound scanning, also called sonography

Nuclear medicine studies

Fluoroscopy studies

Outpatient Surgery

Advantages of using a freestanding facility:

- No long wait for an appointment
- Shorter waiting room time
- Lower co-payments or co-insurance than at a hospital



Diagnostic imaging study cost examples:			
Diagnostic study	In-network hospital	In-network Freestanding facility	COST DIFFERENCE
MRI	\$1,035	\$617	\$418
CT scan	\$589	\$329	\$260

Prices based on national averages.

Dental Insurance

United Healthcare | www.myuhcdental.com

DHMO PLAN 1 (800) 955-4137 / PPO PLAN 1 (877) 816-3596



	UHC DHMO PLAN (Solstice S200A)	UHC DPPO PLAN (National Options PPO 20)
Deductible	NONE	IN: \$25/\$75 OUT: \$50/\$150
Co-Insurance	100%	IN: 100%/90%/60% OUT: 100%/80%/50%
Dentist	COVERED 100%	IN: DED & CO-INS OUT: DED & CO-INS
Specialist	CO-PAY APPLIES	IN: DED & CO-INS OUT: DED & CO-INS
Cleanings	1 EVERY 6 MONTHS	1 EVERY 6 MONTHS
Preventive Network Non Network	MOST PROCEDURES COVERED 100% SOME PROCEDURES HAVE CO-PAYS	IN/OUT: DED WAIVED, COVERED 100%
Basic Coverage Network Non Network	SOME PROCEDURES COVERED 100% MOST PROCEDURES HAVE CO-PAYS	IN: DED & 90% OUT: DED & 80%
Major Coverage	CO-PAY APPLIES	IN: DED & 60% OUT: DED & 50%
Periodontic & Endodontic Coverage	NOT COVERED	BASIC COVERAGE
Orthodontic Coverage Orthodontic Maximum	CO-PAY APPLIES	50% ADULT & CHILD \$2500 ANNUAL MAX
Annual Maximum	NONE	IN/OUT: \$2,500
Dependant Child/Student Age	UP TO AGE 26 (Benefits term on last day of birth month)	UP TO AGE 26 (Benefits term on last day of birth month)
WEEKLY PAYROLL DEDUCTIONS	UHC DHMO PLAN	UHC DPPO PLAN
Employee Only	\$0.00	\$9.63
Employee + One	\$2.77	\$22.91
Employee + Family	\$5.85	\$37.11

SPECIAL NOTE: The above is just a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.

Vision Insurance

United Healthcare | www.myuhcvision.com | 1 (800) 638-3120



UHC VISION		
Exam	**\$10 CO-PAY (EVERY 12 MONTHS)	
Materials	**\$10 CO-PAY Lenses: (EVERY 12 MONTHS) Frames: (EVERY 12 MONTHS)	
Maximum Allowances	NETWORK DOCTOR	NON-NETWORK DOCTOR REIMBURSEMENT
Eye Exam	PAID IN FULL AFTER CO-PAY	\$40 ALLOWANCE
Lenses	PAID IN FULL AFTER CO-PAY	\$40 SINGLE, \$60 BIFOCAL \$80 TRIFOCAL, \$80 LENTICULAR
Contacts-Necessary	PAID IN FULL AFTER CO-PAY	\$210 REIMBURSEMENT
Contacts-Elective	\$105 ALLOWANCE	
Frames	\$50 Wholesale \$130 Retail	\$45 ALLOWANCE

Dependent Child up to Age 26 - Benefit terms at the end of the policy year.

WEEKLY PAYROLL DEDUCTIONS	
Employee Only	\$1.70
Employee + Spouse	\$3.41
Employee + Child(ren) Only	\$3.58
Employee + Family	\$4.50



Life & Accidental Death and Dismemberment Insurance

Lincoln Financial | www.lfg.com | 1 (800) 423-2765



EMPLOYER PAID LIFE & A&D BENEFIT	Your benefits will reduce:
<p>The City of North Miami provides Employer Paid Life Insurance to all Full-Time Employees eligible for benefits. For complete details on your specific level of Life Insurance benefit, please consult your Personnel Department or refer to your Plan Description.</p>	<ul style="list-style-type: none"> • 35% Upon The Attainment Of Age 65 • An Additional 15% of The Original Amount At Age 70 • An Additional 15% of the Original Amount At Age of 75 • Benefits Will Terminate Upon Retirement

Other Benefits Included : Conversion Privilege * Accelerated Benefit

Accidental Death and Dismemberment benefit amount will match your Life Benefit amount. Please see your benefit booklet for full schedule of benefits

*Additional \$50,000 accidental life through Reuben Warner for active employees when enrolled in group life.

VOLUNTARY LIFE & AD&D

Employee Benefit Amount	Your Benefit Will Reduce
<p>Benefit Amount:</p> <ul style="list-style-type: none"> • Choice of \$10,000 Increments • Not to exceed 5 times your annual salary • Maximum Amount \$250,000 • Over Age 70 is \$50,000 <p>Guarantee Issue: \$100,000 at Initial Enrollment</p>	<ul style="list-style-type: none"> • 35% at Age 65 • An Additional 15% of the Original Amount at Age 70 • An Additional 15% of the Original Amount at Age 75 • Benefits Will Terminate at Age 80 or Retirement, whichever is first <p>Other Benefits Included:</p> <ul style="list-style-type: none"> • Waiver of Premium • Accelerated Benefit • Portability After 12 Months
Spouse Benefit Amount	Dependent Benefit Amount
<p>Benefit Amount:</p> <ul style="list-style-type: none"> • \$10,000 	<ul style="list-style-type: none"> • \$5,000 Child: 14 Days to 19 Years (to Age 23 if Full-Time Student)

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum Amount paid for Loss of Life due to an accident or loss of 2 or more members (Hand, Foot, Eye)

1/2 Principal Sum Amount paid for Loss of One Member (Hand, Foot, Eye)

Accidental Death and Dismemberment benefit amount will match your Life Benefit amount. Please see your benefit booklet for full schedule of benefits.

Program Effective Date: The effective date of your coverage will be the first day of the month following the completion of your waiting period. Late entrants are required to complete satisfactory Evidence of Insurability.

Eligibility Requirements: You must be a full-time active employee working at least 30 hours per week. You must also be a permanent employee and be actively at work** on the coverage effective date.

**Actively at work means the full-time performance of all customary duties of your occupation.

If Spouses and Dependent Children are in a 'Period of Limited Activity'* their effective date will not take effect until the day after: (1) his or her final discharge from the health care facility; or (2) resuming the normal activities of a healthy person of the same age and sex.

*Period of Limited Activity means a period when a spouse or child is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.

SPECIAL NOTE: The above is just a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.

Short-Term and Long-Term Disability Insurance

Lincoln Financial | www.lfg.com | 1 (800) 423-2765



Voluntary Short-Term Disability	Voluntary Long-Term Disability
60% Of Your Salary To \$1,500 Is Your Maximum Weekly Benefit <i>This is the amount of benefit you will receive when you are disabled.</i>	Monthly Benefit Equal To 60% Of Your Salary Up To \$8,000 <i>This is the amount of benefit you will receive when you are disabled.</i>
30th Day Accident & 30th Day Sickness Elimination Period <i>This is the number of days you must be disabled before benefit payments start .</i>	Elimination Period of 90 Days <i>This is the number of days you must be disabled before benefit payments start.</i>
Benefit Duration of 9 Weeks <i>This is the period of time that benefits will continue to be paid to you during a period of disability.</i>	To Age 65 Or Social Security Normal Retirement Age Benefit Duration
	Own Occupation 24 Months <i>This is the period of time that the employee need only be disabled from his/her own occupation.</i>

TO CALCULATE YOUR PER PAYCHECK COST PLEASE FOLLOW THESE INSTRUCTIONS:

Voluntary Short-Term Disability	Voluntary Long-Term Disability
Annual Income Divided by 52 weeks \$ _____ (Maximum of \$1,500)	Annual Income Divided by 12 months \$ _____ (Maximum of \$5,000)
Multiply Your Weekly Earnings: X <u> .00411 </u>	Multiply Your Monthly Earnings: X <u> .0015 </u>
Deductions from your Paycheck \$ _____ (52 Deductions - Will Vary Slightly Due to Rounding)	Deductions from your Paycheck \$ _____ (52 Deductions - Will Vary Slightly Due to Rounding)

BENEFIT DEFINITIONS & REQUIREMENTS

Definition of Disability: Disability means you are unable to perform the main duties of your occupation on a full-time basis due to a non-work related injury or sickness. Please see the Lincoln Financial summary of benefits for more detail.

Eligibility Requirements: You must be a permanent employee regularly scheduled to work at least 30 hours per week; be actively at work* on the coverage effective date.

* Actively at work means the full-time performance of all customary duties of your occupation.

Program Effective Date: The effective date of your coverage will be the first day of the month following the completion of your waiting period. Late entrants are required to complete satisfactory Evidence of Insurability.

SPECIAL NOTE: The above is just a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.

EmployeeConnectSM - Practical Help For Life's Challenges

1 (888) 628-4824

There are times in all of our lives when we need a little help. No matter what the issue is, Employee Connect is available 24 hours a day, seven days a week with support, guidance and resources.

Employee Connect Includes:

- Assistance for you or an immediate household family member
- 24/7 telephone and Web access
- Telephone access to legal counsel
- A 25 % discount for services resulting from an attorney referral
- Confidentiality

Work/life services for assistance with

- Parenting and Childcare
- Eldercare
- Relationships
- Work and career
- Financial

LifeKeys - Added benefits to insured, beneficiaries and dependents

1 (855) 891-3684

LifeKeysSM services are provided at no additional cost with our term life and AD&D policies. These services provide assistance not just to beneficiaries but also to insured employees and their dependents. Many of these new services can be used as soon as the plan is in-force — not just when the insured passes away. Services include:

- Free online will preparation
- ID theft information
- Unlimited phone contact with grief counselors and legal and financial specialists
- A combination totaling six in-person sessions for grief counseling, or legal or financial information
- Memorial planning assistance

*LifeKeysSM services, together with TravelConnectSM services, provide a full range of valuable assistance and guidance to insured employees, **their dependents and beneficiaries.***

TravelConnectSM services

A “no-cost benefit” providing you valuable services while traveling

1 (800) 527-0218 - Provider I.D. Number 322541

Traveling just got easier.

As part of your employee benefits package, your Lincoln Financial Group life insurance coverage now includes our *TravelConnect* program, an employee benefit that includes travel, medical, and safety-related services while traveling. Lincoln Financial has partnered with MEDEX Assistance Corporation, a worldwide leader in travel assistance, to make this valuable benefit available to you and your immediate family members.

Business or leisure travel – it’s covered.

The *TravelConnect* benefit is provided at no cost to you and includes a wealth of services when **traveling just 100 miles or more from home. These services are provided regardless if you’re traveling for business or leisure.** Whether you simply want the weather forecast for your travel destination or you need emergency medical assistance halfway around the world, MEDEX has the professional staff and resources to provide support, 24 hours a day, seven days a week.



SPECIAL NOTE: The above is just a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.



ACCIDENT A35275

Coverage 24 hours a day – For Accidents On or Off-the-Job- Worldwide

HOSPITAL INDEMNITY PLAN

Coverage for Hospital Confinement due to Sickness, Surgery, Maternity or Injury

- *Benefits payable for Hospital Confinement*
- *For surgery performed In-Patient or Out-Patient*
- *Wellness Benefit payable every anniversary for a check up*

CANCER INDEMNITY PLAN

Coverage for Cancer Treatment

- *First Occurrence Benefit for initial diagnosis of Internal Cancer*
- *Hospital Confinement benefit for Hospitalization due to Cancer*
- *Radiation, chemotherapy and experimental treatment benefits*
- *Surgery and Anesthesia benefits*
- *Cancer screening benefit for each covered person for each calendar year*

CRITICAL CARE AND RECOVERY

Coverage for the treatment of specified health events including Heart Attack, Stroke, Coronary Artery Bypass Surgery and Third Degree Burns

- *First occurrence benefit for the initial diagnosis*
- *Hospital confinement for a covered illness*
- *ICU confinement benefit for illness and injury*
- *Continuing Care benefits including physical therapy, speech therapy, home health care and doctor visits*

Flexible Spending Account

Open a WageWorks Flexible Spending Account (FSA) and watch your savings grow.

Save between 25% and 40% on everyday expenses.

Open a WageWorks Flexible Spending Account (FSA) during open enrollment and good things happen. You have money ready for eligible expenses not covered by your insurance, saving you 25% – 40%.

How FSAs work.

You can sign up for an FSA during open enrollment. Each paycheck, you set aside some of your pay, before taxes, to use for eligible expenses. This is how you save money: \$100 put into your FSA is \$100 to spend on eligible expenses. Without an FSA, you pay taxes, leaving \$60 or \$75 to pay for the same eligible expenses.

Use the take care® Card.

Use your take care® Card instead of cash or credit at health care providers and pharmacies for eligible services, goods and prescriptions. Typical expenses include co-pays for doctor visits and prescriptions, dental and orthodontia expenses, vision care, prescribed over-the-counter (OTC) drugs and medications and non-drug OTC items and devices.

Using your FSA is easy.

When you elect a health care FSA, your account is funded with the full amount you've chosen at the beginning of the year. As soon as that happens, it's ready to use for eligible expenses. Throughout the year, you "pay your account back" with pre-tax contributions from your paycheck. Accessing your account is easy:

- ▶ **take care® Card.** Use it instead of cash at health care providers and wherever accepted for health-related services and health expenses.
- ▶ **Pay Me Back.** File a claim online, by fax or mail for reimbursement.
- ▶ **On the Go.** Use our mobile website to view your account information.

You can also choose a WageWorks Dependent Care FSA to help with the cost of care for eligible children or aging parents while you are at work. A dependent care FSA works a lot like a health care FSA, but your account is funded each payroll period, so funds are available as contributions are taken from your paycheck.

Flexible Spending Account

Unreimbursed Medical:
\$2,550 Maximum Contribution for the Plan Year

Dependent Day Care:
\$5,000 Maximum Contribution for the Plan Year

Sign up during open enrollment.

Saving up to 40%
on health expenses.

Awesome.

That's exactly what I need.



Employee Benefits

PRE-PAID LEGAL



The City of North Miami’s employees may elect to purchase Legal Insurance through LegalShield Pre-paid Legal on a voluntary basis through payroll deduction. Legal Insurance may be purchased to cover yourself and your spouse. Prepaid Legal offers sever insurance plan options. Rates and brochures may be obtained from Personnel Department.

Examples of Available Services: Traffic Ticket Defense Nationwide; Attorney Letters; Contract and Document Review Consultation for Divorce; Child Custody, Support, Probate, Bankruptcies - Chapter 7, 11 and 13; Immigration; Credit card liability resolution, credit and asset protection and much more; 24/7 on call in an emergency situation, i.e. accident or mistaken identity etc.



DEFERRED COMPENSATION

The City currently offers two deferred compensation programs through ICMA and VALIC. Representatives visit the City monthly.

Deferred compensation is a voluntary, pre-income tax payroll reduction plan available to all full-time employees. You choose an amount of money to be deferred from each paycheck which can be used at retirement to supplement your City pension and Social Security. For income tax purposes, the deferrals are not considered taxable income until withdrawn. Deferrals are considered taxable income for social security purposes. If you will need these funds do not put them in a deferred compensation account. It is not a savings account; it is a pension plan.

HOW MUCH MAY I CONTRIBUTE?

The amount changes from year to year. As of October 2015, the maximum you may defer, according to the IRS is \$18,000 per calendar year except as amended by federal law or regulation. If Age 50 or older, you can defer \$24,000 per year using the Age 50 or older catch-up provision. If you will be retiring within 3 years you have the option of enrolling in the Catch-Up provision and contributing up to \$36,000 in unused deferrals.

HOW CAN I WITHDRAW MONEY?

Please contact the Personnel Administration Department for the appropriate forms.



SECTION 125 Qualifying Events

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, such as additions, deletions and cancellations, depending on whether or not you experience an eligible qualifying event as determined by the Internal Revenue Service (IRS) Code, Section 125. You may change a benefit election upon the occurrence of a valid qualifying event only if the event affects your own, your spouse's or your dependent's coverage eligibility.



If you experience a qualifying event, you must report the qualifying event to Human Resources Department within 30 days of the event. Beyond 30 days, additions and deletions will be denied and you may be responsible both legally and financially for any claims and/or expenses incurred as a result of any dependent(s) who continued to be **enrolled who no longer meet the City of North Miami's eligibility requirements.**

If approved, most election changes will be effective on the date of the qualifying event for additions; cancellations will be processed at the end of the month.

Payroll deductions for health, dental, vision and certain supplemental accident insurance premiums, are deducted from your gross income before **your income is taxed. The City of North Miami's plan is known as a Cafeteria Benefit Plan** and is governed by IRS Code, Section 125. This pre-tax benefit means you pay less tax on a per-pay and annual basis. See examples of Qualifying Life Events for allowable enrollment changes as determined by Section 125 of the IRS Code.

Examples of a Qualifying Life Event

- The birth/adoption/legal custody of a child
- A marriage
- A divorce
- A covered dependent is no longer eligible for coverage
- A dependent returns to full-time student status
- A spouse or dependent child dies
- An increase in your work hours from part-time to full time
- A decrease in your work hour
- A spouse obtains employment
- **A spouse's employment is terminated**
- A child gains or loses coverage with an ex-spouse (responsibility for health coverage changes)

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or **if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).**

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the **Children's Health Insurance Program (CHIP)** or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

For More Information or Assistance

To request special enrollment or obtain more information, please contact your local Human Resources Department.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a **"special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

WOMEN’S HEALTH AND CANCER RIGHTS ACT

ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

	NHP HMO OA F0S4-M3	UHC Choice HMO AHQ6-M1	UHC Choice Plus AHRR-M1	UHC Choice Plus AHLP-M1
Individual	\$250	\$2,000	\$1,500	\$250
Family	\$500	\$4,000	\$3,000	\$500
Co-Insurance	100%	100%	100%	90%

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply for in-network services depending on your plan. If you would like more information on WHCRA benefits, please contact your local Human Resource Representative.

ANNUAL NOTICE

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Please contact your local Human Resource Representative for more information.

NEWBORNS’ AND MOTHER’S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

COBRA

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

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

Employee:	<ol style="list-style-type: none"> 1. Reduction in hours of employment (that disqualifies group insurance participation eligibility); or 2. Termination of employment (for reasons other than gross misconduct).
Spouse of an Employee:	<ol style="list-style-type: none"> 1. The death of your spouse; or 2. A termination of your spouse’s employment (for reasons other than gross misconduct) or a reduction in your spouse’s hours of employment; or 3. Divorce or legal separation from your spouse; or 4. Your spouse becomes entitled to Medicare
Dependent Child of an Employee:	<ol style="list-style-type: none"> 1. The death of a parent; or 2. A termination of the parent’s employment (for reasons other than gross misconduct) or a reduction in the parent’s hours of employment with the Entity; or 3. Parent’s divorce or legal separation; or 4. A parent becomes entitled to Medicare; or 5. The dependent child ceases to be a “dependent child” under the Entity’s group health plan.

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

NOTICE OF PATIENT PROTECTIONS

NHP/UHC generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact NHP at (877) 972-8845 www.mynhp.com or UHC at (800) 825-8792 www.myuhc.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from NHP/UHC or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact NHP at (877) 972-8845 www.mynhp.com or UHC at (800) 825-8792 www.myuhc.com.



MEDICARE PART D

Important Notice About Your Prescription Drug Coverage and Medicare

Attention All Medicare Eligible Employees and Dependents of
City of North Miami's Neighborhood Health Partnership and United HealthCare Plans:

The following information will apply to you only if you or one of your covered family members is currently eligible for Medicare or soon to be eligible for Medicare. In an effort to ensure that all those who are both eligible for Medicare and covered by our plan receive this important information regarding Medicare Part D, we are sending it to all plan members.

Beginning January 1, 2006, Medicare offered prescription drug plans to help you pay for the prescriptions you need. This program is called Medicare Part D. **If you don't join a Medicare Part D plan, you will pay a higher premium unless you already have drug coverage that, on average, is at least as good as the standard Medicare Part D plan.**

Part of the new law required that employers provide Medicare eligible retirees and active employees and dependents with written certification of whether or not the company's prescription drug coverage is "as good as" the standard Medicare Part D-plan. When an employer's plan meets this standard, it is called "creditable".

Please be advised that The City of North Miami's NHP or UHC Plan that covers you and your eligible dependents is CREDITABLE. Creditable coverage means that the employer plan offered has a value equal to or greater than the Medicare Part D plans.

This notice officially confirms:

The fact that your prescription drug coverage is creditable does not prevent you from enrolling in Medicare Part D if you wish. The open enrollment for Part D is November 15 to December 31. However, delaying enrollment in Medicare Part D until a future date will not result in higher premium payments as long as you are covered by a creditable prescription drug plan.

As someone who is Medicare eligible, you will be receiving information on the Medicare Part D plans in your area. Premiums will vary depending upon where you live, but are expected to average about \$32-\$37/Month. If you do decide to enroll, coordination of benefits will be required.

For more information on Medicare Part D, you can read the "Medicare & You" Handbook which will be mailed to you during October, visit www.medicare.gov on the web or call 1-800 MEDICARE (1/800-633-4227). TTY users should call 1-877-846-2048.

If you are Medicare eligible please review the enclosed notice and put it with your other important insurance papers.

If you have any questions, please feel free to contact Human Resources (305) 893-6511.





New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact UHC at 1-888-842-4571 // NHP at 1-877-972-8845.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of North Miami		4. Employer Identification Number (EIN)	
5. Employer address 725 NE 125 Street, 1st Floor		6. Employer phone number (305) 893-6511	
7. City North Miami	B. State FL	9. ZIP code 33161	
10. Who can we contact about employee health coverage at this job? Personnel Department			
11. Phone number (if different from above) 305-893-6511		12. Email address	

Here is some basic information about health coverage offered by this employer:

•As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

Full-time employee are eligible 1st month following 30 days after date of hire.

•With respect to dependents:

We do offer coverage. Eligible dependents are:

Full-time employees with Spouses and Dependents to Age 30. Domestic Partners with Dependents Age30. Part-time employees are not eligible for benefits.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently is eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
 Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____
 Employer won't offer health coverage
 Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

Definition of Dependent

Dependent - the Subscriber's legal spouse or a dependent child of the Subscriber or the Subscriber's spouse or a newborn child of an Enrolled Dependent. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child placed for foster care.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A newborn child of an Enrolled Dependent. The newborn child may be covered from birth to 18 months of age.

To be eligible for coverage under the Contract, a Dependent must reside within the Service Area or reside with the Subscriber who works within the Service Area. Note: This does not apply to your Dependents who reside or work outside the Service Area if your Dependents have agreed to receive Covered Health Services from those providers who participate in our national network of preferred providers. Refer to the definition of "Network Benefits" below.

The definition of Dependent is subject to the following conditions and limitations:

- Under the Patient Protection and Affordable Care Act (PPACA), a Dependent includes any dependent child under 26 years of age.
- **A Child's eligibility for dependent coverage under the PPACA is based solely on the child's age and his or her relationship to the participant.** The plan or issuer may not deny or restrict coverage for a child who is under age 26 based on whether the Child is of the following:
 - The child is financially dependent on the participant; or
 - The Child resides with the participant or with any other person; or
 - The Child is a student or employed.
- A Child can join or remain on your plan even if they are:
 - Married
 - Not living with you
 - Attending School
 - Not financially dependent on you
 - Eligible to enroll in their employer's plan**
- In the event that the Subscriber has a Dependent who meets the following requirements, extended coverage may be available for that Dependent to the end of the calendar year in which the Dependent reaches age 30. Contact your Enrolling Group for details. To be eligible for extended coverage, a Dependent must satisfy the following:

COC.DEF.H.09.FL.KA 65

- Is unmarried and does not have dependent of his or her own;
- Is a resident of Florida or a Student, and
- Does not have coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If such a Dependent's coverage is terminated after the end of the calendar year in which the Dependent reached age 25, the child is not eligible to be covered under the Contract unless the Dependent was continuously covered by Creditable Coverage without a gap in coverage of more than 63 days.

A child who is covered under extended coverage provisions set forth above ceases to be eligible as a Dependent on the last day of the calendar year following the child's attainment of the limiting age or when the child no longer meets the requirements.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

NOTE: The City of North Miami reserves the right to request documentation to further determine the dependent eligibility.

Make a Smart Decision for your Children

Apply for

Fl  **rida**
KidCare

Florida KidCare is a lower-cost health insurance program for children from birth-age 18.

If you cannot afford dependent coverage, you may qualify for dependant insurance coverage through the Florida KidCare Program.



What is Florida KidCare?

Florida KidCare is for kids, not adults. To qualify for premium assistance a child must:

- Be under age 19
- Be uninsured
- Meet income eligibility requirements
- Be a US citizen or qualified non-US citizen
- Not be eligible for Medicaid
- Not be a dependant of a state employee eligible for Health Insurance
- Not be in a public institution

About KidCare:

- There is no charge for Medicaid for children (KidCare Medicaid)
- For other Florida KidCare programs premiums depends on household size and income. Most families pay \$15 or \$20 a month. If you need to pay more, Florida KidCare will let you know
- You may have to pay small charges or copayments for some services
- A child who is part of a federally recognized American Indian or Alaskan Native tribe may qualify for no-cost Florida KidCare coverage

Families who are not eligible for premium assistance may buy **Florida KidCare (MediKids or HealthyKids) at the “full pay” Premium rate.**

For more information contact a Florida KidCare representative to learn more about the program, and if you qualify contact:

[1.888.540.5437](tel:1.888.540.5437) | www.floridakidcare.org

Or contact your Sapoznik Agent for help.



KNOW YOUR NUMBERS

Numbers that count for a Healthy Heart

Source: American Heart Association; heart.org

TOTAL CHOLESTEROL

GOAL: Your total cholesterol score is calculated by the following equation: HDL + LDL + 20% of your triglyceride level. A total cholesterol score of less than 180 mg/dL is considered optimal.

BLOOD PRESSURE

GOAL: Less than 120/80 mmHg

FASTING GLUCOSE

GOAL: Less than 100 mg/dL

BODY MASS INDEX (BMI)

GOAL: Greater than 18.5 but less than 25 kg/m²

WAIST CIRCUMFERENCE

*GOAL: Women: 35 inches or less

*GOAL: Men: 40 inches or less

*if BMI is greater than 25 kg/m²

Cholesterol

American Heart Association Recommendations that all adults age 20 or older have their cholesterol and other traditional risk factors checked every four to six years, and work with their healthcare providers to determine their risk for cardiovascular disease and stroke.

This chart reflects blood pressure categories defined by the American Heart Association.

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Normal	less than 120	and	less than 80
Prehypertension	120 – 139	or	80 – 89
High Blood Pressure (Hypertension) Stage 1	140 – 159	or	90 – 99
High Blood Pressure (Hypertension) Stage 2	160 or higher	or	100 or higher
Hypertensive Crisis (Emergency care needed)	Higher than 180	or	Higher than 110



MAINTAINING A HEALTHY WEIGHT

Why Is a Healthy Weight Important?

Reaching and maintaining a healthy weight is important for overall health and can help you prevent and control many diseases and conditions. If you are overweight or obese, you are at higher risk of developing serious health problems, including heart disease, high blood pressure, type 2 diabetes, gallstones, breathing problems, and certain cancers. That is why maintaining a healthy weight is so important: It helps you lower your risk for developing these problems, helps you feel good about yourself, and gives you more energy to enjoy life.

What Is Overweight and Obesity?

Overweight is having extra body weight from muscle, bone, fat, and/or water. Obesity is having a high amount of extra body fat. Body mass index (BMI) is a useful measure of overweight and obesity. The information on this Web site will provide you with information about BMI (including limitations of this measure) and how to reach and stay at a healthy weight. Talk to your health care provider if you are concerned about your BMI.

What Factors Contribute To a Healthy Weight?

Many factors can contribute to a person's weight. These factors include environment, family history and genetics, metabolism (the way your body changes food and oxygen into energy), and behavior or habits.

Energy Balance

Energy balance is important for maintaining a healthy weight. The amount of energy or calories you get from food and drinks (energy IN) is balanced with the energy your body uses for things like breathing, digesting, and being physically active (energy OUT):

- The same amount of energy IN and energy OUT over time = weight stays the same (energy balance)
- More energy IN than OUT over time = weight gain
- More energy OUT than IN over time = weight loss

To maintain a healthy weight, your energy IN and OUT don't have to balance exactly every day. It's the balance over time that helps you maintain a healthy weight.

You can reach and maintain a healthy weight if you:

- Follow a healthy diet, and if you are overweight or obese, reduce your daily intake by 500 calories for weight loss
- Are physically active
- Limit the time you spend being physically inactive

Source: <http://www.nhlbi.nih.gov/>

How Can I Manage Stress?

It's important to learn how to recognize how stress affects you, learn how to deal with it, and develop healthy habits to ease your stress. What is stressful to one person may not be to another. Stress can come from happy events (a new marriage, job promotion, new home) as well as unhappy events (illness, overwork, family problems).

What is stress?

Stress is your body's response to change. The body reacts to it by releasing adrenaline (a hormone) that causes your breathing and heart rate to speed up, and your blood pressure to rise. These reactions help you deal with the situation.

The problems come when stress is constant (chronic) and your body remains in high gear, off and on, for

How can I cope with it?

Taking steps to manage stress will help you feel more in control of your life. Here are some good ways to cope.

- Try positive self-talk — turning negative thoughts into positive ones. For example, rather than thinking “I can't do this,” say “I'll do the best I can.”
- Take 15 to 20 minutes a day to sit quietly, relax, breathe deeply and think of a peaceful situation.
- Engage in physical activity regularly. Do what you enjoy — walk, swim, ride a bike or do yoga. Letting go of the tension in your body will help you feel a lot better.
- Try to do at least one thing every day that you enjoy, even if you only do it for 15 minutes.



days or weeks at a time. Chronic stress may cause an increase in heart rate and blood pressure.

Not all stress is bad. Speaking to a group or watching a close football game can be stressful, but they can be fun, too. The key is to manage stress properly. Unhealthy responses to stress may lead to health problems in some people.

How can I live a more relaxed life?

Here are some positive healthy habits you may want to develop to manage stress and live a more relaxed life.

- Think ahead about what may upset you. Some things you can avoid. For example, spend less time with people who bother you or avoid driving in rush-hour traffic.
- Learn to say “no.” Don't promise too much.
- Give up the bad habits. Too much alcohol, cigarettes or caffeine can increase stress. If you smoke, make the decision to quit now.
- Slow down. Try to “pace” not “race.” Plan ahead and allow enough time to get the most important things done.
- Get enough sleep. Try to get 6 to 8 hours of sleep each night.
- Get organized. Use “To Do” lists to help you focus on your most important tasks. Approach big tasks one step at a time.



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The Importance of Preventive Care

Maintaining or improving your health is important – and a focus on regular preventive care, along with following the advice of your doctor, can help you stay healthy.

Routine checkups and screenings can help you avoid serious health problems, allowing you and your doctor to work as a team to manage your overall health, and help you reach your personal health and wellness goals. Preventive care focuses on maintaining your health, and establishing your baseline health status. This may include immunizations, vaccines, physical evaluations, lab work, x-rays and medically appropriate health screenings. During your preventive visit, your doctor will determine what tests or screenings are appropriate for you based on many factors such as your age, gender, overall health status, personal health history and your current symptoms or chronic health concerns.

PREVENTIVE CARE FOR ADULTS

The following types of preventive care are available to all adults within specified age ranges or risk groups.

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Aspirin use
- Blood pressure screening
- Cholesterol screening
- Colorectal cancer screening
- Depression screenings
- Diabetes screening
- Diet counseling
- HIV screenings
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling
- Syphilis screening
- Tobacco use screening
- Vaccinations

PREVENTIVE CARE FOR WOMEN

The ACA also mandates coverage for the following preventive services for adult women as part of all non-grandfathered health plans.

- Anemia screening
- Breast cancer genetic test counseling (BRCA)
- Breast cancer mammography screening
- Breast cancer chemoprevention
- Breastfeeding support and counseling
- Cervical cancer screening
- Chlamydia infection screening
- Contraception
- Domestic and interpersonal violence screening and counseling
- Folic acid supplements
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Human papillomavirus (HPV) DNA test
- Osteoporosis screening
- RH incompatibility screening
- Urinary tract or other infection screening
- Well-woman visits

PREVENTIVE CARE FOR CHILDREN

Most health plans must also cover a set of preventive health services for children. These services must be provided at no cost to beneficiaries if they are requested from and delivered by an in-network provider.

- Autism screening
- Behavioral assessments
- Blood pressure screening
- Cervical dysplasia screening
- Depression screening
- Developmental screening
- Dyslipidemia screening
- Fluoride chemoprevention supplements
- Gonorrhea preventive medication
- Hearing screening
- Height, weight and body mass index
- Hematocrit or hemoglobin screening
- HIV screening
- Hypothyroidism screening
- Iron supplements
- Lead screening
- Obesity screening and counseling
- Oral health risk assessment
- Phenylketonuria (PKU) screening
- STI prevention counseling and screening
- Tuberculin testing
- Vaccinations
- Vision screening



In addition to mandated no-cost preventive care, there are other existing preventive services that may be included by an insurer as part of a health group plan. These include things like adult vision and hearing screenings and vitamin and mineral supplements. Check with your insurer to see if additional preventive services are available for your plan's recipients.

Periodic Health Examination Schedule

CLINICAL PREVENTIVE SERVICES FOR NORMAL-RISK MEN			
Intervention	18-35 years	40-50 years	60+ years
Immunizations			
Tetanus-diphtheria (every 10 years)	x	x	x
Varicella (2 doses if none as a child)	x	x	x
Pneumococcal (one dose)			x
Influenza (yearly)			x
Screening			
Blood pressure, height, weight, dental	x	x	x
Alcohol use	x	x	x
Cholesterol (every 5 years)		x	x
Sigmoidoscopy (every 5-10 years)			x
Fecal occult blood (every year)			x
Vision and hearing (periodically)			x
Counseling			
Prostate cancer screening			x
Tobacco, drugs, alcohol, sexually transmitted diseases & safety	x	x	x

CLINICAL PREVENTIVE SERVICES FOR NORMAL-RISK WOMEN			
Intervention	18-35 years	40-50 years	60+ years
Immunizations			
Tetanus-diphtheria (every 10 years)	x	x	x
Varicella (2 doses if none as a child)	x	x	x
Measles, mumps, rubella (1 dose)	x	x	
Pneumococcal (one dose)			x
Influenza (yearly)			x
Screening			
Blood pressure, height, weight, dental	x	x	x
Alcohol use	x	x	x
Pap smear (every 1-3years)	x	x	x
Cholesterol (every 5 years)		x	x
Mammography (every 1-2 years)		x	x
Sigmoidoscopy (every 5-10 years)			x
Fecal occult blood (every year)			x
Vision and hearing (periodically)			x
Counseling			
Calcium intake	x	x	x
Folic acid	x	x	
Hormone replacement therapy		x	x
Mammography screening		x	x
Tobacco, drugs, alcohol, sexually transmitted diseases & safety	x	x	x

SOURCE: *Guide to Clinical Preventive Services*

Periodic Health Examination Schedule

Clinical Preventive Services for Normal Risk Children										
Intervention	Birth	2m	4m	6m	12m	15m	18m	2y	4-6y	11-18y
Immunizations										
Hepatitis B	x	x		x						
Polio		x	x	x					x	
Haemophilus influenzae type B		x	x	x		x				
Diphtheria, Tetanus, Pertussis		x	x	x			x		x	
Measles, mumps, rubella					x				x	x
Varicella					x					
Screening										
Newborn screening (e.g. Hypothyroidism)	x									
Hearing	x									
Head circumference	x	x	x	x	x	x	x	x		
Height and weight	x	x	x	x	x	x	x	x	x	x
Lead					x			x		
Vision	x								x	x
Blood pressure		x			x			x	x	x
Dental health									x	x
Alcohol/Drug use										x
Counseling										
Development, nutrition, & safety	x	x	x	x	x	x	x	x	x	x
Sexually transmitted diseases										x
Tobacco, alcohol, and drug use										x

SOURCE: *Guide to Clinical Preventive Services*



ONLINE ENROLLMENT INSTRUCTIONS

1. Login

ENROLLMENT URL: <https://benefits.plansource.com>

USERNAME

- Your user name is the following: the first initial of your first name, up to the first six characters of your last name, and the last four of your SSN.
For example: If your name is Jane Anderson and the last four of your SSN is 1234, your user name would be janders1234

PASSWORD

- Your birthdate in YYYYMMDD format. For example: If you birthdate is August 14, 1962, your password would be 19620814. At initial login, you will be prompted to change your password



2. Launch Enrollment

- Click on "Enroll in Benefits" picture or "Benefit Elections" link to begin your enrollment
- Click on "Enroll in Benefits – Open" link at the left of the screen to begin your enrollment



SELF-SERVICE ENROLLMENT

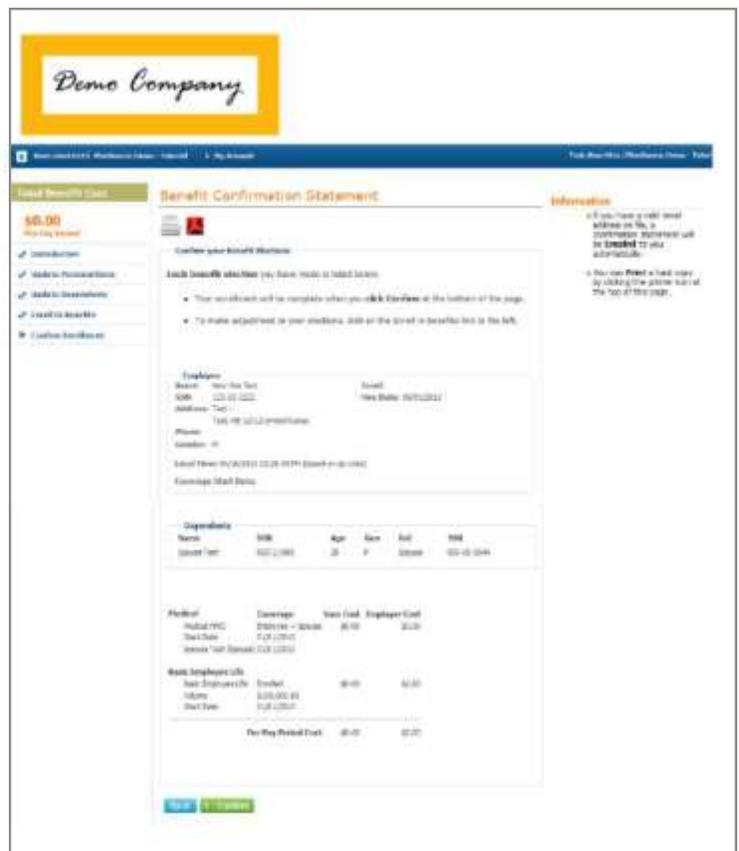
3. Enroll

- Use the links on the left to make your selection
- Follow the enrollment through each step of the enrollment process from top to bottom
- In making your elections, choose the plan option of choice or select the “Decline” option and then select “Continue” after each election has been made



4. Confirm Enrollment Selections

- Once you complete all coverage elections, you will land on the Confirmation Statement. Click the “Confirm Enrollment” button at the bottom of the page to complete your enrollment process.





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