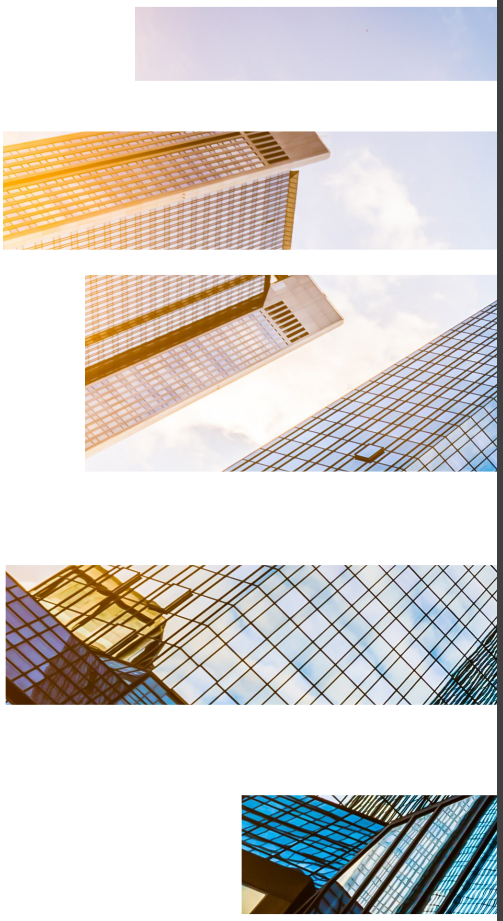
CITY OF NORTH MIAMI



YOUR **BENEFITS.**

YOUR **CHOICES.**

YOUR **HEALTH.**

January 1, 2023 - December 31, 2023

2023 BENEFITS GUIDE

WELCOME

CONTENTS

Introduction

The City of North Miami recognizes that benefits are an important part of your total compensation package. Our benefit program provides competitive and valuable benefits for employees and their dependents while managing the increasing cost.

We are proud to provide our employees and their dependents with a comprehensive benefit package that includes copays for doctor office visits, prescription drugs, and a low out-of-pocket for medical expenses. Aetna will remain our medical carrier of choice for the 2023 Plan Year and we are adding a third lower cost option to our plan offerings.

Also, we are proud to continue to offer you Aetna for Dental & Vision and Mutual of Omaha for Life and Disability coverage.

In addition, we will continue to offer you and your family a wide assortment of voluntary benefits provided by Aflac, including Accident, Hospital & Cancer Indemnity, and Critical Care & Recovery plans.

Eligibility & Enrollment

All active full-time employees working at least 30 hours per week are eligible for benefits the first of the month following 30 days of full-time employment.
Your eligible dependents may also participate in the medical, dental, vision, voluntary life and Aflac plans if you are also enrolled.
An eligible dependent is considered to be:

- Your legally married spouse
- Domestic Partner
- Your child(ren) including:
  - A natural child,
  - A stepchild,
  - A legally adopted child or a child legally placed in the employee's home for the purpose of adoption,
  - A foster child or child whom you or your spouse are the legal guardian,
  - a child of your Domestic Partner, or
  - a child for whom the employee is required to provide health benefits pursuant to the Qualified Medical Child Support Order.
- Dependent children are covered until the end of the calendar year they turn 26. For medical plans, extended coverage to the end of the calendar year in which the dependent reaches age 30 may be available if the dependent meets all of the following requirements:
  - Is unmarried and does not have dependent of his or her own, and
  - Is a resident of the State of Florida or a student, and
  - Does not have coverage as a named subscriber, insured, enrollee or covered person under any other group or individual policy or is not entitled to benefits under Title XVIII of the Social Security Act.

BENEFIT ELECTIONS

Your Elections

The elections that you make will be in effect for the entire plan year unless you experience a Qualifying Life Event or HIPPA Special Enrollment Event.

Changing Your Benefit Elections (HIPAA Special Enrollment)

Changes to benefits may generally only be made during the annual open enrollment period, unless you experience a qualifying event. Examples of qualifying events include:

- Termination of employment
- Family Medical Leave Act (FMLA) leave
- Change in status:
  - Legal marital status
  - Number of dependents including birth, death, adoption, and placement for adoption
  - Dependent satisfies or ceases to satisfy dependent eligibility requirements
  - If your, your spouse's, or your dependents' residence (if the residence is outside of the plan area)
  - Civil Union (consistent with the definition of civil union as defined under specific state laws)
- Change in coverage:
  - Loss of coverage for you, your spouse, or dependent under other group health coverage
  - Change in coverage under a plan of your employer or a plan of your spouse's or dependents' employer
  - The addition or significant improvement of a benefit package option
- HIPAA Special Enrollment rights:
  - An employee or his/her spouse or dependent declined to enroll in group health plan coverage because he/she had other coverage and eligibility for other coverage is lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or other coverage was non-COBRA coverage and employer contributions were terminated
  - A new dependent is acquired as a result of marriage, birth, adoption, or placement of adoption.
  - 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.

SECTION 125

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.

QUALIFYING EVENTS

If you experience a qualifying event, you must report the qualifying event to Personnel 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 entity's eligibility requirements.

CONTACT INFORMATION

CITY OF NORTH MIAMI CONTACTS

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Personnel Administrator
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Dritts@northmiamifl.gov

CARRIER	PHONE #	WEBSITE
Aetna		
Customer Service Medical - Policy #118593 Dental - Policy #119197 Vision - Policy #118593	 866.253.0656 877.238.6200 877.973.3238	 www.Aetna.com www.Aetna.com www.AetnaVision.com
Teladoc		
Customer Service	855.835.2362	www.teladoc.com/aetna
Mutual of Omaha		
Customer Service Basic Life or Voluntary Life Disability	 800.775.8805 800.877.5176	 www.mutualofomaha.com
Legal Shield		
Customer Service Mitch Summer	800.654.7757 954.562.2823	www.legalshield.com
HealthEquity/WageWorks		
Customer Service	866.735.8195	www.healthequity.com/learn
MissionSquare		
Retirement Specialist Augusto Gaymer	Off: 202.759.7096 Cell: 866.886.8026 eFax: 866.573.5771	www.missionsq.org Email: agaymer@missionsq.org
AIG / VALIC		
Retirement Specialist Georgea Tingas	Off: 305.817.2250 Cell: 786.510.1794 Fax: 786.805.4366	www.aig.com/RetirementServices Email: Georgea.tingas@corebridgefinancial.com
Aflac Supplemental Insurance		
Customer Service Sharona Abad	800.992.3522 305-335-6515	www.aflac.com Sharona_Abadi@us.aflac.com
Nationwide Pet Insurance		
Customer Service	877.738.7874	www.petinsurance.com/northmiamifl
WellCents Financial Advisors		
Senior Specialist Dianna Tucciarone	Off: 407.815.5619 Fax: 407.740.6113	Dianna.tucciarone@nfp.com
Corporate Synergies Group		
BenefitsVIP	866.293.9736	Solutions@benefitsvip.com

ADVOCACY

BenefitsVIP®
Help starts here.

HELP STARTS HERE

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members resolve your benefits issues.

For service that's confidential and responsive, contact:

866.293.9736

Monday—Friday
8:30am—8:00pm (ET)
Fax: 856.996.2775
solutions@benefitsvip.com

QUESTIONS ANSWERED HERE

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer benefit questions and quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day and all calls adhere to privacy best practices.

BenefitsVIP.com

WEBSITE

Stay informed with the latest health news, biometric tools, calculators and information at **benefitsvip.com**

BLOG

HealthDiscovery.org is a lifestyle blog with wellness articles, tips, quizzes, recipes, and more!

MEDICAL

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HOW TO FIND A PROVIDER

Follow the steps below to locate a participating medical provider:

STEP 1: Go to www.aetna.com

STEP 2: Click on "Find a doctor"

STEP 3: If you are already a member log in; if not, under Guests select "Plan from an employer"

STEP 4: Enter search location "and click "Search"

STEP 5: Under "Aetna Open Access Plans" select "Elect Choice EPO (Open Access)".

BASE PLAN	OPEN ACCESS ELECT CHOICE $4000 EPO
BENEFIT	**IN-NETWORK ONLY**
Annual Deductible (Calendar Year)	**Individual:** $4,000 **Family:** $8,000
Out-of-Pocket Maximum	**Individual:** $8,000 **Family:** $16,000
Member Co-Insurance	30%
Preventive Care Adult Preventive Care, Adult Annual Physical Exam or Well-Child Care	No Charge
Outpatient Care Primary Care Physician office visits Specialist office visits Outpatient facility surgery Outpatient surgery physician / surgeon fees Telehealth / Virtual Visits	 $25 Copay $45 Copay Deductible, then 30% Deductible, then 30% **PCP:** $25 Copay | **Spec:** $45 Copay
Inpatient Hospitalization Facility Physician / Surgeon	 Deductible, then 30% Deductible, then 30%
Emergency Care Ambulance (when medically necessary) Hospital Emergency Room Urgent Care	 Deductible, then 30% $350 Copay (waived if admitted) $75 Copay
Independent Outpatient Lab & X-Ray Blood Work & X-Rays Advanced Imaging (MRI, CT/PET Scans)	 No Charge Deductible, then 30%
Mental Health Inpatient (Physician / Facility) Outpatient office visits	 Deductible, then 30% $45 Copay
Prescription Drugs **Retail Pharmacy** (31 day supply) Tier 1 / Tier 2 / Tier 3 **Mail Order** (90 day supply) Tier 1 / Tier 2 / Tier 3 **Specialty Drugs** Preferred Specialty/Non-Preferred Specialty	 $10 / $50 / $90 $20 / $100 / $180 20% ($150 Maximum)
Weekly Contributions Employee Only Employee + Spouse Employee + Children Employee + Family	 **$0.00** **$106.85** **$86.12** **$210.75**

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MEDICAL

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MID PLAN | OPEN ACCESS ELECT CHOICE $2500 EPO

BENEFIT	IN-NETWORK ONLY
Annual Deductible (Calendar Year)	**Individual:** $2,500 **Family:** $5,000
Out-of-Pocket Maximum	**Individual:** $6,000 **Family:** $12,000
Member Co-Insurance	10%
Preventive Care Adult Preventive Care, Adult Annual Physical Exam or Well-Child Care	No Charge
Outpatient Care Primary Care Physician office visits Specialist office visits Outpatient facility surgery Outpatient surgery physician / surgeon fees Telehealth / Virtual Visits	 $25 Copay $45 Copay Deductible, then 10% Deductible, then 10% **PCP:** $25 Copay | **Spec:** $45 Copay
Inpatient Hospitalization Facility Physician / Surgeon	 Deductible, then 10% Deductible, then 10%
Emergency Care Ambulance (when medically necessary) Hospital Emergency Room Urgent Care	 Deductible, then 10% $350 Copay (waived if admitted) $75 Copay
Independent Outpatient Lab & X-Ray Blood Work & X-Rays Advanced Imaging (MRI, CT/PET Scans)	 No Charge $300 Copay
Mental Health Inpatient (Physician / Facility) Outpatient office visits	 Deductible, then 10% $45 Copay
Prescription Drugs **Retail Pharmacy** (31 day supply) Tier 1 / Tier 2 / Tier 3 **Mail Order** (90 day supply) Tier 1 / Tier 2 / Tier 3 **Specialty Drugs** Preferred Specialty/Non-Preferred Specialty	 $10 / $50 / $90 $20 / $100 / $180 20% ($150 Maximum)
Weekly Contributions Employee Only Employee + Spouse Employee + Children Employee + Family	 **$5.00** **$125.05** **$102.66** **$239.15**

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DOWNLOAD THE AETNA APP

Get the Aetna Health app by Texting "AETNA" to 90156 for a link to download the app.

- Connect to care, search for facilities, procedures and medications.
- Find in network providers accepting new patients.
- Estimate and compare costs.

WELL-BEING SERVICES AT CVS MINUTECLINIC®

Aetna offers well-being service at CVS Pharmacy® and Target® locations: Choose from these services:

- Smoking cessation
- Weight management
- Diabetes monitoring
- High cholesterol monitoring
- High blood pressure monitoring

You can work one-on-one with providers to help create personalized health plans and get the support you need for a healthier you.

Go to MinuteClinic.com to find the closest location and make appointments or view wait times.

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Pharmacy Options

If you take prescription medication, you can save money by becoming an informed consumer and using the same buying techniques that you use when shopping for other goods and services.

Ways to save on your prescription drugs include:

- Generic medications
- Price comparison
- Drug substitution
- Discount prescription cards
- Over the counter drug substitutes
- Pharmaceutical company assistance programs

Local Pharmacies often offer free antibiotics and low priced medications.

Inquire at your local CVS, Publix, Target and Walmart pharmacies as to what discount programs are available.

GoodRx.com

Save up to 80% on most prescription drugs at virtually every U.S. pharmacy.

The GoodRx mobile app allows you to get prescription drug prices on-the-go with coupons built into the app. Show your smartphone to the pharmacist to save.

Visit GoodRx.com to learn the terms of their current program.

	BUY–UP PLAN	OPEN ACCESS ELECT CHOICE $500 EPO
BENEFIT		**IN-NETWORK ONLY**
Annual Deductible (Calendar Year)		**Individual:** $500 **Family:** $1,000
Out-of-Pocket Maximum		**Individual:** $5,000 **Family:** $10,000
Member Co-Insurance		20%
Preventive Care Adult Preventive Care, Adult Annual Physical Exam or Well-Child Care		No Charge
Outpatient Care Primary Care Physician office visits Specialist office visits Outpatient facility surgery Outpatient surgery physician / surgeon fees Telehealth / Virtual Visits		 $20 Copay $40 Copay Deductible, then 20% Deductible, then 20% **PCP:** $20 Copay | **Spec:** $40 Copay
Inpatient Hospitalization Facility		$750 Copay / Admission
Emergency Care Ambulance (when medically necessary) Hospital Emergency Room Urgent Care		 Deductible $350 Copay (waived if admitted) $50 Copay
Independent Outpatient Lab & X-Ray Blood Work & X-Rays Advanced Imaging (MRI, CT/PET Scans)		 No Charge $200 Copay
Mental Health Inpatient (Physician / Facility) Outpatient office visits		 $750 Copay / Admission $40 Copay
Prescription Drugs **Retail Pharmacy** (31 day supply) Tier 1 / Tier 2 / Tier 3 **Mail Order** (90 day supply) Tier 1 / Tier 2 / Tier 3 **Specialty Drugs** Preferred Specialty/Non-Preferred Specialty		 $10 / $50 / $90 $20 / $100 / $180 20% ($150 Maximum)
Weekly Contributions Employee Only Employee + Spouse Employee + Children Employee + Family		 **$10.00** **$156.49** **$130.50** **$290.47**

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VIRTUAL VISITS

Teladoc® Virtual Visits

With Virtual Visits, it's easy to video chat with a doctor 24/7— whenever, wherever.

Teladoc gives you 24/7 access to board-certified doctors by phone, video or mobile app.

Talk to a doctor in minutes and get a diagnosis, treatment and prescription (if needed), for non-emergency medical needs.

Quality care when and where you need it.

Use a Virtual Visit for everyday medical conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- And more

How to access

By phone: 1-855-Teladoc (1-855-835-2362)

By video: Teladoc.com/aetna

By mobile app: download the Aetna Health or Teladoc app to get started

TELADOC®

VIRTUAL VISITS MAY SAVE YOU TIME AND MONEY.

On-demand within minutes *(Avg. wait 10 – 15 mins.; guaranteed within 1 hour or consult is FREE of charge).* Also by appointment.

AETNA DISCOUNTS

How To Get Started

Log in to your member website at www.Aetna.com once you're an Aetna member, to shop and receive your member discounts and find information on how to order products.

- Find vision, hearing or natural therapy professionals
- Sign up for a weight-loss program
- Buy health products
- Find a gym

Aetna Discount Programs

Aetna offers built-in plan discounts with no referrals, claims or limits for you and your family.

Vision Discounts on:

- Designer Frames
- Prescription Lenses and Contact Lenses
- Eye Exams
- Lasik Surgery

You can visit many doctors in private practice. Plus, national chains like LensCrafters®, Target Optical® and Pearle Vision®.

Hearing Care Discounts on:

- Hearing aids
- A two to three year supply of batteries and then join a discount battery mail-order program
- Free in-office service of hearing aids for one year

Fitness Discounts on:

- Gym memberships
- Health coaching
- At-home weight-loss program
- Wearable fitness devices

Oral Health Care Product Discounts on:

- Teeth whitening
- Electronic toothbrushes
- Replacement brush heads

Savings on Natural Products and Services

- Therapeutic massage
- Acupuncture
- Chiropractic care
- Nutrition services

Savings on at-home products

- Blood pressure monitors
- Pedometers and activity trackers
- Electrotherapy TENS units

WHERE TO GO FOR CARE

	Non-emergency Care from anywhere	Non-emergency In-person care	Non-emergency In-person care	Urgent In-person care	Emergency In-person care
	Teladcoc®	**Primary Care Physician (PCP)**	**MinuteClinic®**	**Urgent Care Center**	**Emergency Room**
Care Options	Teladoc gives you 24/7 access to board-certified doctors by phone, video or mobile app. Talk to a doctor in minutes and get a diagnosis, treatment, and prescription (when needed), for non-emergency medica needs	Your PCP is the best option for in-person, non -emergency care. To find in-network PCPs near you, log in to your member website.	MinuteClinic offers convenient care 7 days a week from certified nurse practitioners and physician assistants at select CVS Pharmacy® and Target stores nationwide.	Urgent care centers provide quick care for serious, but not life-threatening, situations. Many urgent care centers offer imaging, X-ray and lab services.	The emergency room (ER) is for emergencies that can permanently impair or endanger your life. Using the ER for non-life-threatening issues can be very costly and probably means a very long wait time.
When to use	•Allergies •Flu •Bronchitis •Sinus infection •Food poisoning •Rash •Poison ivy/oak •Sunburn •Sore throat •Headache/migraine •Eye infection and more	•Physicals (wellness, screening) •Vaccinations & injections •Chronic condition management (heart disease, diabetes, arthritis, etc.) •Acute care (sinus infections and injuries) •Urgent care may be available by appointment	•Minor illnesses & injuries •Screenings & monitoring •Skin conditions •Vaccinations & injections •Wellness & physicals •Women's services •Travel health •Visit minuteclinic.com to confirm services available at your location	•Back/neck pain •Cuts that require stitches •Minor burns •Flu •Sprains •Fractures •Bronchitis •Headaches and more	•Chest pain •Severe abdominal pain Trouble breathing Uncontrollable bleeding Symptoms that may put your life at risk
Availability	24 hours a day 7 days a week 365 days a year	Weekdays during business hours *(May be open extended hours and/or Saturdays)*	7 days a week *(including evenings and weekends)*	Many open 7 days a week with extended hours	24 hours a day 7 days a week 365 days a year
How to access	By phone: **1-855-Teladoc (1-855-835-2362)** By video: **Teladoc.com/aetna** By mobile app: download the **Aetna Health** or **Teladoc app** to get started	By appointment only	At select CVS Pharmacy and Target stores Schedule an appointment at **minuteclinic.com** or through the CVS Pharmacy app	Walk in	Walk in
Average wait time	On-demand within minutes *(Avg. wait 10 – 15 mins.; guaranteed within 1 hour or consult is FREE of charge)* Also by appointment	Average wait time of 22 minutes upon arrival	Make an appointment at minuteclinic.com	15 - 45 minutes typically	2 - 4 hours for non-emergency care typically
Average cost to you	**$** •Total cost is $47 or less. •Pay at the time of your consult. •No balance is ever billed to you.	**$$** •Pay your copay at appointment, if applicable. •Pay your estimated patient responsibility at time of visit, if applicable. •You may be billed for any balance.	**$** •No-cost or low-cost access to all covered services. •Pay your estimated patient responsibility at time of visit, if applicable. •You may be billed for any balance.	**$$$** •Pay your copay at time of visit, if applicable. •Pay your estimated patient responsibility at time of visit, if applicable. •You may be billed for any balance.	**$$$$** •Pay your copay at time of visit, if applicable. •Pay your estimated patient responsibility at time of visit, if applicable. •You may be billed for any balance.

DENTAL

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FINDING A PPO DENTAL PROVIDER

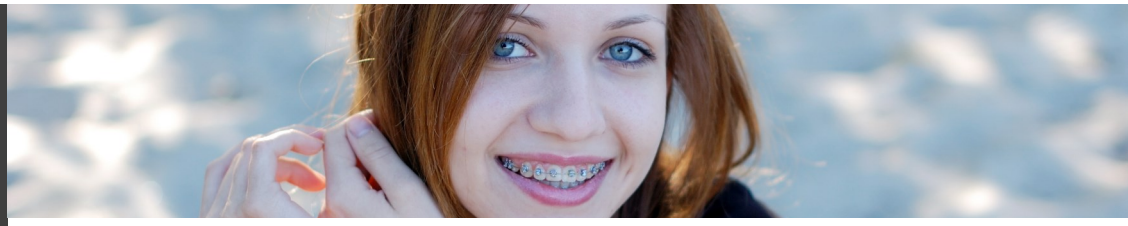
Follow the steps below to locate a participating dental provider:

STEP 1: Go to www.aetna.com
STEP 2: Click on "Find a doctor"
STEP 3: If you are already a member log in; if not, under Guests select "Plan from an employer"
STEP 4: Enter search location "and click "Search"
STEP 5: Under Select a Plan, scroll down to "Dental PPO/ PDN with PPO II network" select "Dental PPO/PDN with PPO II
STEP 6: Select "Dental Care" then select type of dentist

FINDING A DHMO DENTAL PROVIDER

Follow the steps below to locate a participating dental provider:

STEP 1: Go to www.aetna.com
STEP 2: Click on "Find a doctor"
STEP 3: If you are already a member log in; if not, under Guests select "Plan from an employer"
STEP 4: Enter search location "and click "Search"
STEP 5: Under Select a Plan scroll down to "DMO®/DNO/ Managed Dental" select "DMO® /DNO"
STEP 6: Select "Dental Care" then select "Dentists (Primary Care)



DENTAL PLANS	PPO PLAN		DHMO PLAN
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Calendar Year Deductible	**Individual:** 25 **Family:** $75	**Individual:** $50 **Family:** $150	**Individual:** $0 **Family:** $0
Benefit Maximum Per Calendar Year	$2,500		N/A *Primary Dentist Election Required*
Diagnostic & Preventive Services Prophylaxis (Cleanings); Oral Examinations; Topical Fluoride & Sealants (up to age 16); X-rays; Bitewing; & Space Maintainers	100%	100%	Some Procedures Covered @ 100% (See Fee Schedule)
Basic Services Fillings; Extractions; Oral Surgery; Endodontics; Periodontics; Periodontal Surgery; Anesthesia	90%	80%	Copays Apply (See Fee Schedule)
Major Services Bridge and Dentures; Crowns, Inlays, Onlays, Repairs of Dentures, Crowns, Inlays and Onlays	60%	50%	Copays Apply (See Fee Schedule)
Orthodontic Services Adults & Children	50% $2,500 Lifetime Max	50% $2,500 Lifetime Max	Copays Apply No Lifetime Max
Weekly Contributions			
Employee Only	**$8.26**		**$0.00**
Employee + Spouse	**$19.94**		**$3.41**
Employee + Child(ren)	**$22.86**		**$4.26**
Employee + Family	**$34.53**		**$7.67**

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VISION

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PPO VISION PLAN

BENEFIT	IN-NETWORK (ALLOWANCE)	OUT-OF-NETWORK (REIMBURSEMENT)
Eye Exam	$10 Copay	Up to $25
Frequency (within a consecutive 12-mo. period)		
Exam	12 months	12 months
Lenses	12 months	12 months
Frames	12 months	12 months
Contact Lenses (in lieu of eyeglasses)	12 months	12 months
Frames	$130 Allowance + 20% off Balance	Up to $65
Lenses		
Single Vision Lenses	$10 Copay	Up to $20
Bifocal Vision Lenses	$10 Copay	Up to $40
Trifocal Vision Lenses	$10 Copay	Up to $65
Lenticular Vision Lenses	$10 Copay	Up to $65
Standard Progressive	$75 Copay	Up to $40
Contact Lenses (in lieu of glasses)		
Medically Necessary	$0 Copay	Up to $200
Elective Conventional Contact Lenses	$115 Allowance	Up to $80
Elective Disposable Contact Lenses	$115 Allowance	Up to $92
Weekly Contributions		
Employee Only	**$1.62**	
Employee + Spouse	**$3.07**	
Employee + Child(ren)	**$3.23**	
Employee + Family	**$4.75**	

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this conflicts in any way with the contract, the contract will prevail.

FINDING A VISION PROVIDER

Follow the steps below to locate an in-network Vision provider:

STEP 1: Go to www.aetna.com
STEP 2: Click on "Find a doctor"
STEP 3: If you are already a member log in; if not, under Guests select "Plan from an employer"
STEP 4: Enter search location "and click "Search"
STEP 5: Under Select a Plan, scroll down to "Vision Plan" select "Aetna Vision Preferred"

BASIC LIFE / AD&D

Mutual of Omaha

HOW BASIC LIFE/AD&D INSURANCE CAN HELP

Life and AD&D insurance may provide additional financial support by:

- Assisting your family with the cost of your funeral or medical bills
- Covering household expenses
- Relieving debt you might leave behind
- Leaving an inheritance for your loved ones or an organization you are passionate about

EMPLOYER-PAID BASIC LIFE/AD&D

CITY OF NORTH MIAMI provides all full-time, benefit eligible employees with Basic Life/Accidental Death & Dismemberment (AD&D) coverage through Mutual of Omaha at no cost to you. Please refer to the PlanSource enrollment system for the coverage amounts specific to your eligibility class.

- AGE REDUCTION: Basic Life/AD&D benefits are reduced to 65% at age 65, to 50% at age 70, to 35% at age 75, and Benefits Term at Retirement (unless otherwise eligible).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE: AD&D insurance coverage provides protection in the event of accidental death, loss of hands, feet, and/or vision. The benefit is equal to the life benefit. Please refer to the Mutual of Omaha contract for specific benefit plan design information and availability relevant to your specific eligibility class.

BE SURE TO UPDATE YOUR BENEFICIARY INFORMATION

A beneficiary is the person or entity you name in a life insurance policy to receive the death benefit.

You can name:

- One person
- Two or more people
- The trustee of a trust you've set up
- Your estate

Note: If you don't name a beneficiary, the death benefit will be paid to your estate.

TWO LEVELS OF BENEFICIARIES:

Your Life Insurance policy should have both primary and contingent beneficiaries. The primary beneficiary receives the death benefit upon your passing. Contingent beneficiaries receive the death benefit if the primary beneficiary cannot be located. If no primary or contingent beneficiaries are located, the death benefit will be paid to your estate.

As part of naming beneficiaries, you should identify them as clearly as possible and include their Social Security Numbers. This will make it easier for the Life Insurance company to confirm their identity and decrease the likelihood of potential disputes.

VOLUNTARY LIFE

Mutual of Omaha

VOLUNTARY LIFE

In addition to the Basic Life/AD&D insurance, employees have the option to elect voluntary coverage through Mutual of Omaha.

COVERAGE GUIDELINES			
	MINIMUM	GUARANTEE ISSUE	MAXIMUM
For You	$10,000	5 times annual salary, up to $100,000	5 times annual salary, up to $250,000 In $10,000 increments
Spouse	$5,000	100% of employee's benefit, up to $30,000	100% of employees benefit, up to $125,000 in $5,000 increments
Children	$10,000	$10,000	$10,000

If you are ***newly eligible,*** you may elect five (5) times your annual salary up to $100,000 for yourself and 100% of your elected amount up to $30,000 for your spouse without medical underwriting. Any elections over these amounts will require an Evidence of Insurability (EOI) form to be completed.

Open Enrollment Annual Increase:
If you are currently enrolled and your coverage amount is less than the guarantee issue limit, you may increase your coverage by up to 2 increments ($20,0000) without completing an EOI.

All other increases will be subject to completing evidence of insurability (EOI).

THINGS TO REMEMBER:

- You pay just one payroll deduction for child coverage, no matter how many children you are covering
- The rates for spouse coverage are based on the employee's age
- Spouse coverage terminates at employee's age 80.
- You must enroll in coverage in order to elect coverage for your dependents
- Benefits reduce to 65% at age 65, to 50% at age 70, and to 35% at age 75.
- Payroll deductions may vary due to rounding

EVIDENCE OF INSURABILITY FORM

An Evidence of Insurability (EOI) form is required if you or your spouse are electing an amount over the Guarantee Issue Limit (GI).

NOTE: Benefit coverage and payroll deductions will not take effect until EOI is approved by Mutual of Omaha.

DISABILITY

Mutual of Omaha

THINGS TO REMEMBER:

Pre-Existing Condition Exclusion (STD)

The pre-existing condition limitation under the short-term disability plan is 3/6. This which means, any condition that you received medical attention for in the 3 months prior to your effective date of coverage, that results in a disability during the first 6 months of coverage, would not be covered.

Evidence of Insurability Form For LTD

An evidence of insurability (EOI) form is required to come on to the plan during annual enrollment or if coverage was previously waived during the initial eligibility period.

Note: LTD coverage and payroll deductions will not take effect until EOI is approved by Mutual of Omaha.

Pre-Existing Condition Exclusion (LTD)

The pre-existing condition limitation under the long-term disability plan is 3/12. This which means, any condition that you received medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.

Voluntary Short-Term Disability

You have the opportunity to elect an income replacement supplement. This coverage is designed to replace a portion of your income should you become unable to work due to a non-work related injury or sickness. A brief summary of the plan is outlined in the following chart. Please refer to your Mutual of Omaha summary for additional details, including limitations and exclusions.

VOLUNTARY SHORT-TERM DISABILITY SCHEDULE OF BENEFITS	
Benefits Begin	31st day Accident/Sickness
Benefit Duration / Payable	9 weeks
Percentage of Income Replaced	60%
Maximum Weekly Benefit	$1,500
Minimum Weekly Benefit	$25
Pre-Existing Condition Limitation	Look back 3 months / not covered first 6 months on plan

Voluntary Long-Term Disability

Long term disability will provide coverage once the short-term disability has concluded.. Please refer to your Mutual of Omaha summary for additional details, including limitations and exclusions.

VOLUNTARY SHORT-TERM DISABILITY SCHEDULE OF BENEFITS	
Benefits Begin	91st day Accident/Sickness
Benefit Duration / Payable	To the later of age 65, your normal Social Security Retirement Age or 3.5 years
Percentage of Income Replaced	60%
Maximum Monthly Benefit	$8,000
Minimum Monthly Benefit	$100
Pre-Existing Condition Limitation	Look back 3 months /not covered first 12 months on plan

Long-term disability benefits begin after the end of the elimination period and can be payable for up to two years if you are unable to perform the duties of your regular occupation and payable in accordance with the table above if you are unable to perform the duties of any occupation.

Employee Assistance Program

Available Services When you need help the most

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Benefits include:

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Legal assistance and financial services
    - Will preparation
    - Legal library & online forms
- Resources for:
    - Work/Life balance
    - Substance abuse
- Dependent and elder care assistance & referral services
- Access to a library of educational articles, handouts and resources via a website

We are here for you

Visit the Employee Assistance Program website to view timely articles and resource on a variety of financial, well-being, behavioral and mental health topics

Mutualofomaha.com/eap
Or call us: 800.316.2796

VALUE ADDED BENEFITS

Mutual of Omaha

HEARING DISCOUNT PROGRAM

The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries.

www.amplifonusa.com/mutualofOmaha.com

Or call: 888-534-1747

WILL PREP SERVICES

This service allows employees to access online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property.
Visit:

www.willprepservices.com
Registration code: Mutualwills

TRAVEL ASSISTANCE

If you have a medical emergency while you are more than 100 miles away from home, you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24/7. The can assist with medical care, emergency medial evacuations, prescription assistance and more:

Within US: 800.856.9947

DEFERRED COMPENSATION

ICMA-RC is now
MissionSquare RETIREMENT

Augusto C. Gaymer
Retirement Plans Specialist

Work
(202) 759-7096

Cell:
866) 886-8026; Option #1

eFax:
(866) 573-5771

Email:
agaymer@missionsq.org

Web: www.missionsq.org

AIG

AIG / VALIC

Andrew Jimenez
Financial Advisor

Work
305.817.2250

Cell
786.774.1645

Fax
786.777.7626

Andrew.Jimenez@aig.com

DEFERRED COMPENSATION

The City currently offers two deferred compensation programs through Mission Square/ICMA and AIG/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. Below is a snapshot of contribution limits for 2023:

	2023	2022
457 (b)	**$22,500**	$20,500
Traditional and Roth IRAs	**$6,500**	$6,000

Employee age 50 and older may contribute additional amounts depending upon the plan as shown below:

	Catch-Up Contribution
457 Plans	$7,500
IRAs	$1,000

SUPPLEMENTAL INSURANCE

Aflac

ACCIDENT PLAN

- Coverage 24 hours a day
- For accidents on and off-the-job

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 preventive care visit

CANCER INDEMNITY PLAN

Coverage for Cancer Treatment

- First occurrence benefit for initial diagnosis or 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

CONTACT INFO

For more information and detailed benefit summaries contact:

www.aflac.com

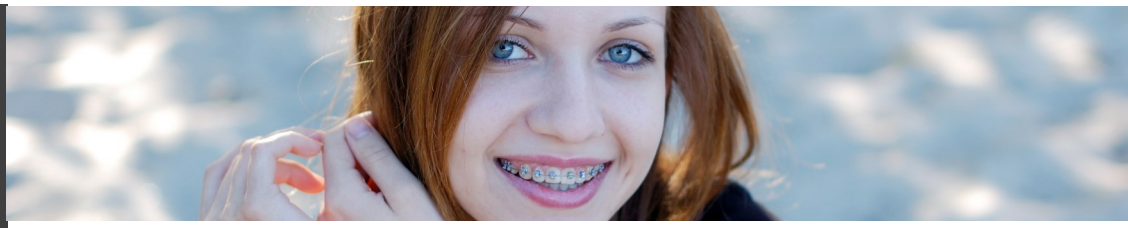
800-992-3522

Contact:

Sharona Abadi
Sharona_Abadi@us.aflac.com

HEALTHCARE FSA

HealthEquity | WageWorks



FOR A FULL LIST OF QUALIFIED MEDICAL FSA EXPENSES VISIT:

HEALTHEQUITY.COM/QME

EXAMPLES OF NON-QUALIFIED FSA EXPENSES:

- Childcare
- Cosmetic surgery
- Electrolysis or hair removal
- Household help
- Teeth whitening

GO MOBILE:

HTTPS://
PARTICIPANT.WAGEWORKS.COM

YOU MAY BE ASKED FOR DOCUMENTATION THAT IT IS A QUALIFIED EXPENSE SO PLEASE KEEP YOUR RECEIPTS

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

What is a Healthcare Flexible Spending Account?
FSAs are tax-advantaged accounts that let you use pre-tax dollars to pay for eligible medical expenses which also include covered dental and vision expenses. You can use an FSA to save on average 30 percent (actual savings may vary). Because FSAs are tax favored account the IRS limits the amount of money you can contribute each year. In 2023 the maximum contribution is $3,050.

Sample qualified medical expenses:

Medical Care
- Doctor Visits
- Hospital Services
- Prescriptions

VIsion
- Eye Exams
- Prescriptions Glasses/Contacts
- LASIK surgery

VIsion
- Eye Exams
- Prescriptions Glasses/Contacts
- LASIK surgery

Dental
- Cleanings
- Orthodontia
- Filings/Crowns

Alternative care
- Chiropractic
- Acupuncture
- Medically Necessary Massage

Use it or lose it: Plan carefully when making your election. You will have a grace period of 2.5 months after the end of the plan year to use the balance of the funs. After that date any funds left in the account will be forfeited.

DEPENDENT CARE FSA

HealthEquity | WageWorks

Dependent Care Flexible Spending Account

What is a Dependent Care Flexible Spending Account?
A DCFSA is a pre-tax benefit account used to pay for dependent care services. Dependent Care Flexible Spending Account (DCFSA) funds can pay for services such as preschool, summer day camp, before or after school programs, and child or elder daycare.

Eligible Dependent Care Flexible Spending Account dependents include:

- A child under the age of 13 who resides with you and for whom you are entitled to a personal tax exemption as a dependent.
- A spouse, parents, or other **tax-dependent** adults who reside with you and who are physically or mentally incapable of self-care.

DEPENDENT CARE FSA PRETAX CONTRIBUTION LIMITS	AMOUNT
Married and files a joint tax return or single/head of household	$2,500 for each tax return files up to the $5,00 maximum
Married and files a separate return	$5,000 maximum

Example DCFSA eligible Expenses

Childcare for your child under 13 year old

- Nanny and au pair services
- Before and after school programs
- Summer day Camp
- Preschool

Elder care

- Elder day care
- Work-related custodial elder care

Use it or lose it: Plan carefully when making your election. You will have a grace period of 2.5 months after the end of the plan year to use the balance of the funs. After that date any funds left in the account will be forfeited.

FOR A FULL LIST OF QUALIFIED DEPENDENT CARE FSA EXPENSES VISIT:

HEALTHEQUITY.COM/LEARN/DEPENDENT-CARE-EXPENSES/

EXAMPLES OF NON-QUALIFIED DEPENDENT CARE FSA EXPENSES

- Dance lessons
- Educational, learning or study skills services
- Field trips
- Kindergarten tuition
- Language classes
- Private school tuition

LEGAL SHIELD

ADVICE & GUIDANCE

Know and protect all of your legal rights, unlimited consultation, any personal or family matter even on pre-existing conditions

- Family Matters
- Estate Planning
- Mortgage/ Refinance/ Credit
- Consumer Issues
- Debt Collection
- Inheritance
- IRS Audits
- Medical Disputes

Contact: Mitch Summer
Cell 954-562-2823

LEGAL SHIELD

PREVENTIVE LEGAL SERVICES

Unlimited toll-free telephone consultations for personal and business questions. Monday-Friday.

24/7 /365 Access to our attorney's for **emergency** situations

Personal letters/Phone calls on your behalf plus.

Personal contract/ Document

review on your behalf. Before you sign anything, have your attorney review all your family's documents and contracts.

Will, Living Will & Health Care proxy preparation

Prepared for the employee and spouse. Healthcare Power of Attorney, Guardianship Annual Reviews & Updates

MOTOR VEHICLE LEGAL SERVICES

(Available 15 days after enrollment. No drugs or alcohol involved)

Moving Traffic violation representation

Major Legal Expenses: Defense of criminal charges resulting from operation of a moving vehicle.

Up to 2.5 hours for help with:

- Suspended license
- Personal injury/Property damage collection $2,000 or less

TRIAL DEFENCE

Help with attorney fees for defense of civil and covered work-related criminal charges for you and your spouse.

60 hours of assistance first membership year.

Scheduled benefits increase to a maximum of:

2nd year:120 hours of assistance

3rd year: 180 hours of assistance

4th year: 240 hours of assistance

5th year: 300 hours of assistance

I.R.S. AUDIT LEGAL SERVICES .

Schedule benefits up to 50 hours of professional services from your Provider Attorney to help defray the cost of audit representation.

OTHER LEGAL SERVICES

Other legal services not specifically covered by the membership are available at a 25% discount from the Provider Attorney's standard or corporate hourly rate for representation.

USING YOUR BENEFITS

Online: www.mylegalshield.com

Mobile App

PET INSURANCE

Nationwide® is on your side

PET INSURANCE

You work hard to provide your family with everything they need. So whether your family includes kids with two feet or kids with four paws, you know what responsibility looks like.

My Pet Protection® from Nationwide® helps you provide your pets with the best care possible by reimbursing you for vet bills. You can get cash back for

HOW NATIONWIDE PET INSURANCE CAN HELP

Coverage is available 24/7 for:

- Injuries
- Illnesses
- Preventative Care

For City of North Miami Employee Preferred Pricing Visit: petinsurance.com/northmiamifl

or call 877.738.7874 for more information or to obtain a no-obligation quote.

FINANCIAL WELLNESS ANNOUNCEMENT

The City of North Miami has partnered with WellCents to provide financial wellness education and awareness, access to financial advisors and so much more. To launch this partnership, The City of North Miami is pleased to introduce WellCents and the Financial Wellness Assessment! WellCents is a comprehensive, holistic financial wellness solution designed to help you create confidence in your financial life. Our goal is to help you develop a real-life action plan to move you toward being financially well, and in turn, help you secure a financially sound retirement.

Dianna Ranalli Tucciarone
Senior Specialist
Retirement
1060 Maitland Center Commons | Suite 360 | Maitland, FL 32751
P: 407.815.5619 | F: 407.740.6113 | dianna.tucciarone@nfp.com | NFP.com

Be A Wise Health Care Consumer

Knowing your four health numbers is key to a healthier you.
At your annual check-up, ask your doctor for your four health numbers (Blood Pressure, Cholesterol, Blood Sugar and BMI -Body Mass Index).

Blood pressure:
A telltale sign for possible heart disease, stroke and kidney disease. Understanding your blood pressure numbers is key to controlling high blood pressure. The American Heart Association recommends a normal Blood Pressure range of Systolic mm Hg (upper number) Less then 120 and Diastolic mm HG (lower number) Less than 80 (120/80).
Cholesterol
HDL is good. LDL is bad. Keeping both in check is essential. The American Heart Association (AHA) recommends 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.
Blood Sugar
A leading determinant for the onset of diabetes. What is a normal blood sugar level? And how can you achieve normal blood sugar? For someone without diabetes, a fasting blood sugar on awakening should be under 100 mg/dl. Before-meal normal sugars are 70–99 mg/dl. “Postprandial” sugars taken two hours after meals should be less than 140 mg/dl.
Body Mass Index (BMI)
The measure of body fat based on height and weight that applies to adult men and women. In general, BMI is an inexpensive and easy-to-perform method of screening for weight category, for example underweight, normal or healthy weight, overweight, and obesity. There are many calculators online to assist you with obtaining your BMI.
https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

Do you know your financial health numbers?

Knowing them is just as important as knowing your overall health numbers. Your financial health comes down to a series of ratios. Here’s where you should start:
1. Credit Score: Your FICO credit score—a ratio determined independently by three credit bureaus and based primarily on your track record of paying bills on time – is about far more than just being approved for loans.

2. Retirement Savings Rate: There is no single, correct dollar amount to put aside for retirement, which is why most projections rely on percentages. The most important one is how much of your salary you should put aside for retirement, which experts peg at 15%.

3. Emergency Fund: The number you need to know: How many months could you survive on your savings? The key is to achieve an overall balance in your finances, with about half your income going toward fixed expenses like rent and utilities, 20% for financial goals like savings, and 30% for day-to-day expenses like groceries and gas, advises Vera Gibbons, personal finance consultant - mint.com

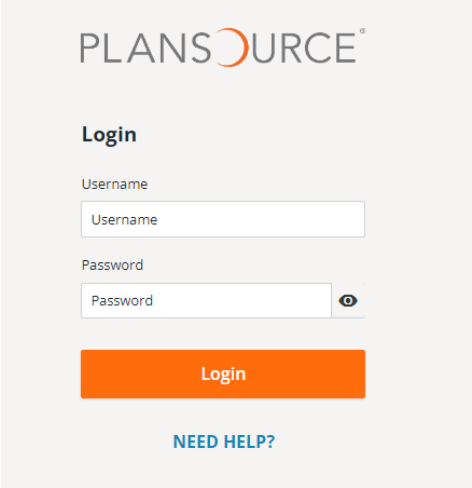
4. Net Worth: People tend to think of this number as their “wealth,” says LearnVest’s von Tobel, but it’s not really about how much you have at any given point. Rather, people should use net worth as a starting point to see how they are doing down the road.

PLANSOURCE

PLANSOURCE ONLINE ENROLLMENT INSTRUCTIONS

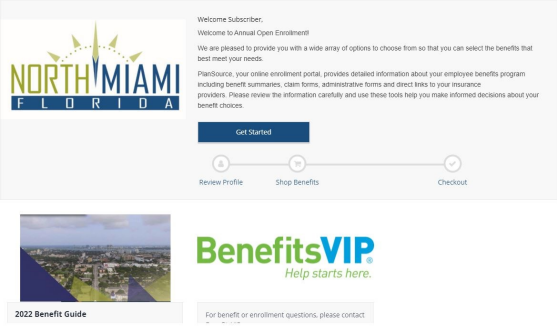
STEP 1:

- Login to PlanSource at https://benefits.plansource.com using the credentials below:
- USERNAME: First initial of your First Name + up to the first six characters of your Last Name + Last four (4) digits of your SSN. Example: John Employee, whose SSN is 000-00-1234, would have a username of JEMPLOY1234; and John Plan, whose SSN is 000-00-9876 would have a username of Jplan9876.
- PASSWORD: Please use your existing password to login. If you have forgotten, click on the "Need Help?" link to reset it. You will be prompted to enter your Username and the email address that we have on file in PlanSource.



STEP 2:

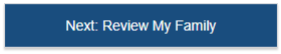
Click "Get Started" to begin the enrollment process.



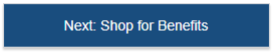
STEP 3:

You will be asked to review your personal information then scroll down and click on "Next: Review My Family"

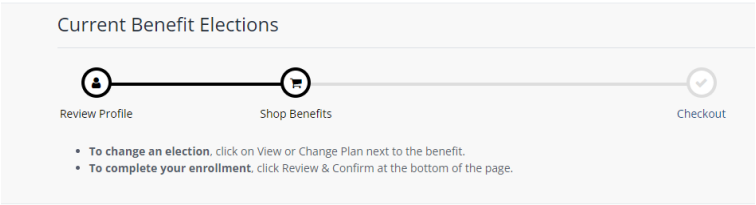
STEP 4:



You can now review your family information. You can now add a family member, edit a family member or remove a family member. When done click on "Next: Shop for Benefits"



PLANSOURCE

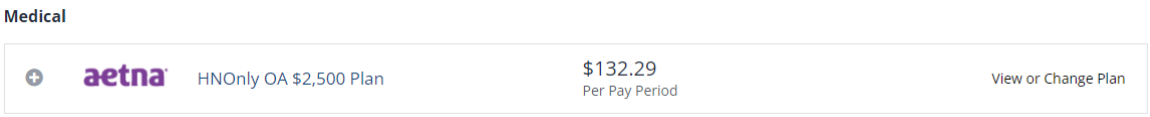


Step 5:

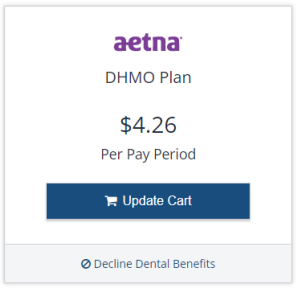
This page will show you your current elections and give you the opportunity to add, change or remove plans,

If this page reflects the benefits you would like for the 2022 plan year you will click "Review and Checkout"

Step 6:
If you would like to change a plan election click "View or Change Plan" benefit plan you would like to change.



You will then choose the plan you wish to enroll in or click on the decline coverage box. Then click on "Update Cart"



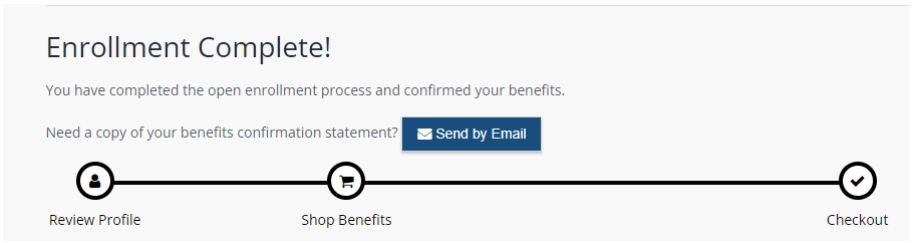
Step 6:

Please continue to follow the prompts as you move through your elections, they will vary based on the choices you make. When you have completed making your choices you will then click on "Review and Checkout"

Step 7:

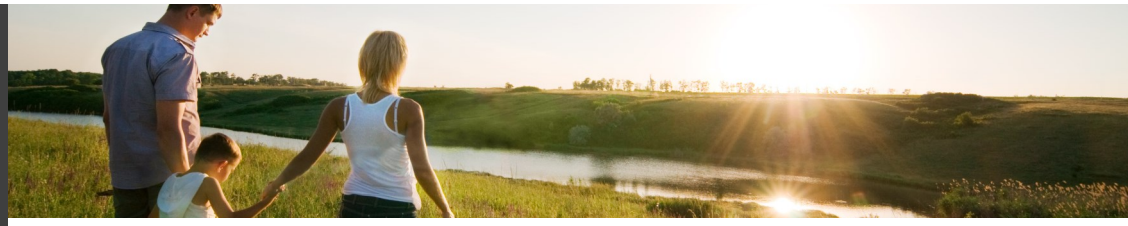
Click on "Checkout"

Your enrollment is now complete you can have a copy of your enrollment emailed to yourself by clicking "Send by Email"



Don't miss this final step, your enrollment is not complete until you

MEDICARE PART D



Important Notice from The City of North Miami
About Your Prescription Drug Coverage and Medicare

If you and/or your covered dependents are not Medicare eligible, this document is for information purposes only.

However, if any of your covered benefit eligible dependents are Medicare eligible, please read this information carefully so that you and your dependents can make an informed decision regarding their prescription drugs.

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with The City of North Miami and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of North Miami has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage. Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

When can you join a Medicare Drug Plan?
Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current City of North Miami group health plan coverage will not be affected. You and your dependents can enroll in a Part D plan as a supplement to, or in lieu of, the group health plan coverage. However, if your existing prescription drug coverage is under a Medigap policy, you cannot have an existing prescription drug coverage and Part D coverage. If you enroll in Part D coverage, you should inform your Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium as of the date the Part D coverage starts.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into The City of North Miami benefit plan during an open enrollment period.

MEDICARE PART D

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with The City of North Miami and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & you" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

Visit www.medicare.gov
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
Call your State Health Insurance Assistance Program for personalized help.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TYY 1-800-325-0778).

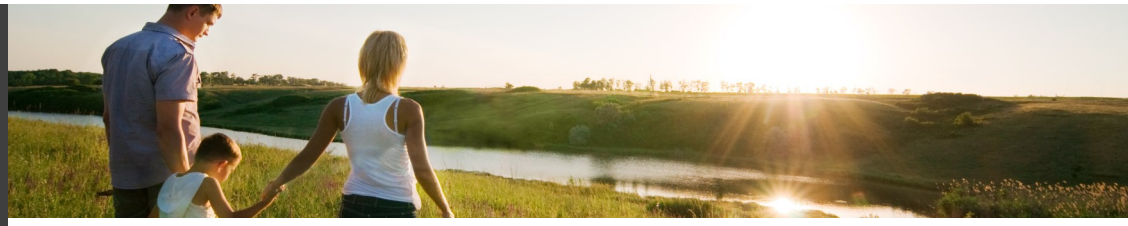
For more information about this notice or your current prescription drug coverage contact:

Name of Entity/Sender:	City of North Miami
Contact--Position/Office:	Personnel Office
Address:	776 NE 125 Street 1st Floor
Phone Number:	North Miami, FL 33161

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through The City of North Miami changes. You also may request a copy.

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

DISCLOSURES



NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.
Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:
1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
- The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

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

DISCLOSURES

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

f you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA: Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA: Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS: Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA: Medicaid
Website:
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO: Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA: Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA: Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA: Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA-Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS: Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY: Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA: Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE: Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711

MASSACHUSETTS: Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

MINNESOTA: Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI-Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA: Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA: Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA: Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE: Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY: Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK: Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA: Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA: Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

DISCLOSURES

OKLAHOMA: Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON: Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA: Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND: Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA: Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA: Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS: Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH: Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT: Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA: Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON: Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA: Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid
Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)

WISCONSIN: Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING: Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

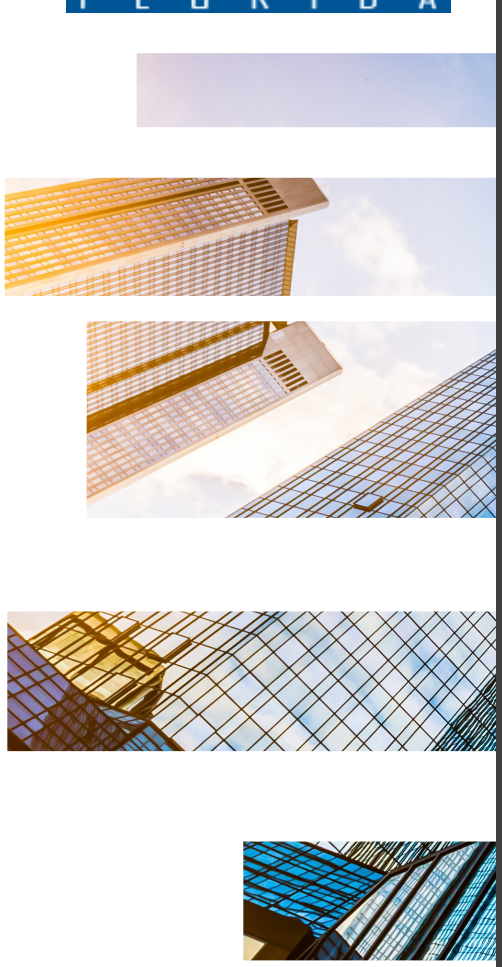
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

NOTES

NORTH MIAMI
FLORIDA



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