EMPLOYEE BENEFIT HIGHLIGHTS

2018
Thank you for being an Employee of the City of Miramar!

As a City of Miramar employee, you help shape the quality of life for our residents, and each of us plays an important role in fulfilling the City’s mission. The City’s high-quality, comprehensive benefits are among the rewards you receive in return as part of your total compensation package. Our health and welfare benefits program provides both choice and value to meet the needs of our diverse workforce.

We are pleased that for Plan Year 2018, there are no changes to our providers, and your premiums will remain the same. We know how important benefits are to you and that making benefits choices can be overwhelming. This Benefits Highlights booklet provides you with resources to assist you in making selections that best fit you and your family’s needs. I strongly encourage you to take the time to thoroughly and carefully review the booklet.

During Open Enrollment, you will have the opportunity to make your selections and/or change your coverage. Our HR Benefits Analysts are available to address your benefits questions or refer you to the appropriate resource, if needed. Additionally, we will have an Aetna representative available to address any specific health plan concerns you may have during the open enrollment period. If you have elected or would like to continue your coverage under COBRA, contact the Human Resources Department for more information.

We thank you for your commitment to a healthier you and the value you bring to the City!

Regards,

Melanie McLean
Human Resources Director
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This booklet is merely a summary of benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Miramar reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.
# Contact Information

<table>
<thead>
<tr>
<th>Human Resources</th>
<th>Human Resources Department</th>
<th>Phone: (954) 602-3836</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Insurance</td>
<td>Aetna</td>
<td>Customer Service: (855) 281-8858 <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Pharmacy and Mail Order Program</td>
<td>Aetna Rx Home Delivery</td>
<td>Customer Service: (888) 792-3862 <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Dental Insurance</td>
<td>Delta Dental</td>
<td>DPPO Customer Service: (800) 521-2651 DHMO Customer Service: (800) 422-4234 <a href="http://www.deltadentalins.com">www.deltadentalins.com</a></td>
</tr>
<tr>
<td>Vision Insurance</td>
<td>EyeMed</td>
<td>Customer Service: (866) 723-0513 <a href="http://www.eyemed.com">www.eyemed.com</a></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>AmeriFlex</td>
<td>Customer Service: (888) 868-3539 <a href="http://www.myameriflex.com">www.myameriflex.com</a></td>
</tr>
<tr>
<td>Supplemental Insurance</td>
<td>Aflac</td>
<td>Customer Service: (800) 433-3036 <a href="http://www.aflacgroupinsurance.com">www.aflacgroupinsurance.com</a> Agent: Margaret Pearson Phone: (561) 881-1964 Email: <a href="mailto:margaret_pearson@us.aflac.com">margaret_pearson@us.aflac.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>Aetna Resources for Living</td>
<td>Customer Service: (888) 238-6232 <a href="http://www.mylifevalues.com">www.mylifevalues.com</a></td>
</tr>
<tr>
<td>Legal Services</td>
<td>Preferred Legal Plan</td>
<td>Customer Service: (888) 577-3476 <a href="http://www.preferredlegal.com">www.preferredlegal.com</a></td>
</tr>
<tr>
<td>Employee Benefits Center</td>
<td>BenTek Support</td>
<td>Customer Service: (888) 523-6835 Email: <a href="mailto:support@mybentek.com">support@mybentek.com</a> <a href="http://www.mybentek.com/cityofmiramar">www.mybentek.com/cityofmiramar</a></td>
</tr>
<tr>
<td>Claims Resource Center</td>
<td>Aetna Member Services</td>
<td>Customer Service: (855) 281-8858</td>
</tr>
</tbody>
</table>
What’s Not Changing for 2018

Medical Insurance – The City will continue to offer two medical plans through Aetna.

- Aetna Health Network Plan
- Aetna Managed Choice (POS) Plan

Dental Insurance: The City will continue to offer dental insurance through Delta Dental.

- Delta Dental PPO Plan
- Delta DentalCare DHMO

Vision Insurance – The City will continue to offer a vision plan through EyeMed Vision Care.

Flexible Spending Accounts: Employees are required to re-elect any and all FSA enrollment elections for the 2018 calendar year.

Variable Hour Employees: As required under the Health Care Reform’s Affordable Care Act (ACA), variable hour employees (for example part-time employees) who satisfy the requirements under the Act will be eligible to participate in the Aetna Medical Plans for 2018. Variable hour employees eligible for 2018 benefits will be notified.

The Affordable Care Act (ACA) 1095C Form: All employees who participated in one of the City’s Aetna Medical Plans during 2017 will receive a 1095C form in the mail from the City to file with their 2017 tax return. These forms will be mailed out at the same time as the W-2 forms.

BenTek is mobile friendly! You can access BenTek using any device such as a Smartphone, Tablet, Computer etc. You will notice that it is a cleaner look, and functions the same.

For questions regarding your eligibility or offered plan benefits, please contact the Human Resources Department.

Passive Enrollment for 2018

If you are changing your coverage, you will be required to make a benefits election during Open Enrollment in order for your new coverage to be effective on January 1, 2018; however, if you are not changing your existing coverage, you do not need to make an election through BenTek. The exception to this is if you are interested in participating in a Health Care or Dependent Care Flexible Spending Account (FSA). FSAs do not automatically restart; they must be re-elected every year.
Introduction

The City of Miramar provides a comprehensive compensation package including health and welfare benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to the City’s Personnel Policies, applicable Union Contracts and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If further explanation or assistance is needed regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact the Human Resources Department.

Summary of Benefits and Coverage

A Summary of Benefits & Coverage (SBC) for the medical plan is provided as a supplement to this booklet being distributed to new hires and existing employees during open enrollment. The summary is an important item in understanding the benefit options. A free paper copy of the SBC document may be requested or is available as follows:

From: The Human Resources Department
Address: 2300 Civic Center Place, First Floor
Miramar, FL 33025
Phone: (954) 602-3836
At Website URL: www.mybentek.com/cityofmiramar

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

If there are questions about the plan offerings or coverage options, please contact the Human Resources Department.

Online Benefit Enrollment

The City provides employees with an online benefits enrollment platform through BenTek’s Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual open enrollment period, new hire orientation, or qualifying events.

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

To Access the Employee Benefits Center:

- Log on to www.mybentek.com/cityofmiramar
- Sign in using a previously created username and password or click “Create an Account” to set up a username and password.
- If employee has forgotten username and/or password, click on the link “Forgot Username/Password” and follow the instructions.
- Once logged on, navigate to the menu in order to review current elections, learn about benefit options, and make elections, changes or beneficiary designations.

For technical issues directly related to using the EBC please call (888) 5-BenTek (523-6835) or email BenTek Support at support@mybentek.com, Monday through Friday, during regular business hours from 8:30 a.m. to 5:00 p.m.

To access group insurance benefits online, log on to: www.mybentek.com/cityofmiramar

Please Note: Link must be addressed exactly as written (Due to security reasons, the website cannot be accessed by Google or other search engines.)
Group Insurance Eligibility

The City’s group insurance plan year is January 1 through December 31.

Employee Eligibility

Based on the following classifications, benefit-eligible employees may participate in the group medical and dental insurance options.

Classification 1 — Employees scheduled to work an average of 37.5 hours or more per week.

Classification 2 — Employees working an average of 30 to 37.4 hours per week during the measurement period.

Employees hired from the 1st to the 15th of the month are eligible for coverage the first day of the next month.

Employees hired from the 16th to the 31st of the month are eligible for coverage the first day of the subsequent month.

Termination

If an employee separates employment from the City, insurance will continue through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

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

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to age 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant’s spouse

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the dependent child turns age 26. An over-age dependent may continue to be covered on the medical plan to the end of the calendar year in which the dependent child reaches age 30, if the dependent meets the following requirements:

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

Dental Coverage: A dependent child may be covered to the end of the calendar year in which the dependent child turns age 19; or to the end of the calendar year in which the dependent child turns age 30, if a full-time or part-time student.

Vision Coverage: A dependent child may be covered through end of the calendar year in which the dependent child turns age 26; or to end of calendar year the dependent child turns age 30 if unmarried, no dependents of his or her own, is a resident of Florida or a part-time or full-time student.

Disabled Dependents

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

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

Proof of disability will be required upon request. Please contact Human Resources if further clarification is needed.
Group Insurance Eligibility (Continued)

**Taxable Dependents**

Employees covering adult children under certain group insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the dependent child reaches age 26. Beginning January 1 of the calendar year in which the dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, employee will be charged an additional premium on a post-tax basis to continue coverage for such dependents. Contact the Human Resources Department for further details if covering an adult child who will turn age 27 any time during the upcoming calendar year or for more information.

**Domestic Partner**

Domestic Partners may be eligible to participate in the City’s Group Insurance Plans and are required to complete a declaration of Domestic Partnership. The IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to domestic partner coverage, unless specific IRS guidelines have been met. Employee insuring Domestic Partner and/or child dependents of a Domestic Partner may be required to pay “imputed income tax” on premium deductions and should consult their tax professional. Please contact the Human Resources Department for more information.

**Qualifying Events and IRS Code Section 125**

**IRS Code Section 125**

Premiums for medical, dental, and vision insurance, and/or certain Aflac policies and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to employee’s pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse, or dependent’s coverage eligibility. An “eligible” qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and due to the qualifying event.

**Examples of Qualifying Events:**

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

**IMPORTANT NOTES**

Employee who experiences a qualifying event must contact the Human Resources Department within 30 days to make the appropriate changes to coverage. Beyond 30 days, requests will be denied and the employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of the employee or dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes are effective on the first of the month following the qualifying event. Newborns are effective on the date of birth and marriage is effective on the date of occurrence. Cancellations will be processed at the end of the month. In the event of death, coverage will terminate the date following the death. Employee will be required to furnish valid documentation supporting a change in status or “Qualifying Event.”
Medical Insurance

The City of Miramar offers medical insurance through Aetna to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plan please refer to Aetna’s Summary of Benefits and Coverage (SBC) document or contact Aetna’s customer service.

### Medical Insurance – Aetna – Health Network Only Plan

**26 Payroll Deductions - Per Pay Period Cost**

<table>
<thead>
<tr>
<th>Tier of Coverage</th>
<th>Classification 1</th>
<th>Classification 1</th>
<th>Classification 1</th>
<th>Classification 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GAME</td>
<td>Police</td>
<td>Unrepresented &amp; Firefighters</td>
<td>Eligible PT Employee</td>
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<tr>
<td>Employee Only</td>
<td>$0.00</td>
<td>$15.00</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
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<td>Employee + 1 Dependent</td>
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<td>Employee + 2 or More Dependents</td>
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</table>

### Medical Insurance – Aetna – Managed Choice POS Plan

**26 Payroll Deductions - Per Pay Period Cost**

<table>
<thead>
<tr>
<th>Tier of Coverage</th>
<th>Classification 1</th>
<th>Classification 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GAME</td>
<td>Police</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$0.00</td>
<td>$15.00</td>
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<tr>
<td>Employee + 1 Dependent</td>
<td>$145.60</td>
<td>$189.56</td>
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<tr>
<td>Employee + 2 or More Dependents</td>
<td>$338.33</td>
<td>$462.79</td>
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</tbody>
</table>

Aetna | Customer Service: (855) 281-8858 | www.aetna.com
**Aetna – Health Network Only Plan At-A-Glance**

<table>
<thead>
<tr>
<th>Network</th>
<th>Health Network Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible (CYD)</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>In-Network</td>
</tr>
<tr>
<td>Family</td>
<td>Does Not Apply</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Member Responsibility</td>
<td>Does Not Apply</td>
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<tr>
<td><strong>Calendar Year Out-of-Pocket Limit</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$6,350</td>
</tr>
<tr>
<td>Family</td>
<td>$12,700</td>
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<tr>
<td><strong>What Applies to the Out-of-Pocket Limit?</strong></td>
<td>Deductible, Coinsurance, Copays and Rx</td>
</tr>
</tbody>
</table>

**Physician Services**

- Primary Care Physician (PCP) Office Visit: $20 Copay
- Specialist Office Visit (No Referral Required): $40 Copay
- Spinal Manipulation Therapy (60 Visits Per Calendar Year): $25 Copay

**Non-Hospital Services; Freestanding Facility**

- Clinical Lab (Blood Work): Quest*: No Charge
- X-rays: No Charge
- Advanced Imaging (MRI, PET, CT): $100 Copay Per Scan
- Outpatient Surgery at Surgical Center: $150 Copay
- Physician Services at Surgical Center: No Charge

**Hospital Services**

- Inpatient Hospital (Per Admission): $250 Copay
- Outpatient Surgery: $150 Copay
- Physician Services at Hospital: No Charge
- Emergency Room (Copay Waived if Admitted): $250 Copay
- Urgent Care: $75 Copay

**Mental Health/Alcohol & Substance Abuse**

- Inpatient Hospitalization (Per Admission): $250 Copay
- Outpatient Services (Per Visit): $20 Copay

**Prescription Drugs (Rx)**

- Generic – Tier 1: $10 Copay
- Preferred Brand Name – Tier 2: $30 Copay
- Non-Preferred Generic and Brand Name – Tier 3: $60 Copay
- Specialty: 25% Coinsurance
- Mail Order Drug (90 Day Supply): $20/$60/$120 Copay

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**Locate a Provider**

To search for a participating provider, contact Aetna’s customer service or visit www.aetna.com. When completing the necessary search criteria, select Aetna Health Network Only network.

**Plan References**

*Quest Diagnostics is the preferred lab for blood work through Aetna. When using a lab other than Quest, please confirm they are contracted with Aetna’s Health Network Only Network prior to receiving services.

**Important Notes**

- Services received from providers or facilities not in the Health Network Only Network will be denied.

**Notes**

- A $2,500 (single) / $5,000 (family) pharmacy cost share maximum is included in the in-network calendar year out-of-pocket limit.
## Aetna – Managed Choice POS Plan At-A-Glance

### Network

<table>
<thead>
<tr>
<th>Calendar Year Deductible (CYD)</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
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<tr>
<td>Single</td>
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<td>Family</td>
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### Open Access Managed Choice

<table>
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<tr>
<th>Coinurance</th>
<th>Member Responsibility</th>
<th>0%</th>
<th>20%</th>
</tr>
</thead>
</table>

### Calendar Year Out-of-Pocket Limit

| Single | $6,350 | $2,000 |
| Family | $12,700 | $4,000 |

What Applies to the Out-of-Pocket Limit?

Deductible, Coinsurance, Copays and Rx

### Physician Services

| Primary Physician Office Visit | $25 Copay | 20% After CYD |
| Specialist Office Visit       | $50 Copay | 20% After CYD |
| Spinal Manipulation Therapy (60 Visits Per Calendar Year) | $25 Copay | 20% After CYD |

### Non-Hospital Services; Freestanding Facility

| Clinical Lab (Blood Work):Quest** | No Charge | 20% After CYD |
| X-rays                             | No Charge | 20% After CYD |
| Advanced Imaging (MRI, PET, CT)   | 0% After CYD | 20% After CYD |
| Outpatient Surgery at Surgical Center | $100 Copay After CYD | 20% After CYD |
| Physician Services at Surgical Center | 0% After CYD | 20% After CYD |

### Hospital Services

| Inpatient (Per Admission)          | $250 Copay After CYD | 20% After CYD |
| Outpatient Surgery                | $100 Copay After CYD | 20% After CYD |
| Physician Services at Hospital    | 0% After CYD | 20% After CYD |
| Emergency Room (Copay Waived if Admitted) | $300 Copay | $300 Copay |
| Urgent Care Center                | $75 Copay | 20% After CYD |

### Mental Health/Alcohol & Substance Abuse

| Inpatient Hospitalization (Per Admission) | $250 Copay After CYD | 20% After CYD |
| Outpatient Services (Per Visit)         | $20 Copay | 20% After CYD |

### Prescription Drugs (Rx)***

| Generic – Tier 1                      | $10 Copay | 30% Coinsurance After Applicable Copay |
| Preferred Brand Name – Tier 2         | $30 Copay |       |
| Non-Preferred Generic and Brand Name – Tier 3 | $60 Copay |       |
| Specialty                             | 25%       | Not Covered |
| Mail Order Drug (90 Day Supply)       | $20/$60/$120 Copay | Not Covered |

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**Locate a Provider**

To search for a participating provider, contact Aetna’s customer service or visit www.aetna.com. When completing the necessary search criteria, select Aetna Open Access Managed Choice Plan network.

**Plan References**

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

**Quest Diagnostics is the preferred lab for bloodwork through Aetna. When using a lab other than Quest, please be sure to confirm they are contracted with Aetna’s Open Access Managed Choice Network prior to receiving services.*

***A $2,500 (single)/$5,000 (family) pharmacy cost share maximum is included in the in-network and out-of-network calendar year out-of-pocket limit.*
Dental Insurance

Delta Dental DHMO Plan

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

Dental Insurance – Delta Dental – DeltaCare DHMO Plan

26 Payroll Deductions – Per Pay Period Cost

<table>
<thead>
<tr>
<th>Tier of Coverage</th>
<th>Classification 1: FT Benefit Eligible Employees</th>
<th>Classification 2: PT Benefit Eligible Employees</th>
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</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$0.00</td>
<td>$3.14</td>
</tr>
<tr>
<td>Employee + 1 Dependent</td>
<td>$2.82</td>
<td>$8.78</td>
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<tr>
<td>Employee + 2 or more Dependents</td>
<td>$4.74</td>
<td>$12.61</td>
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In-Network Benefits

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

The DHMO plan’s schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following page. Please refer to the plan’s summary of coverage document for a detailed listing of charges and what is covered.

Out-of-Network Benefits

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

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Benefit Maximum

There is no calendar year benefit maximum.

IMPORTANT NOTES

- Each covered family member may receive two (2) routine cleanings per calendar year (1 every 6 months) covered under the preventive benefit. Additional cleanings are available at the charge of a copay.
- Referrals and prior authorizations are required to see specialists (oral surgeon, endodontics, periodontist or pediatric dentistry) within the network.
- Waiting periods and age limitations may apply for some services.
- Pediatric services are limited to children up to age seven (7); unless medical necessity is approved by Delta Dental.

Delta Dental | Customer Service: (800) 422-4234 | www.deltadentalins.com
## Delta Dental – DeltaCare DHMO Plan At-A-Glance

### Network

<table>
<thead>
<tr>
<th></th>
<th>DeltaCare USA</th>
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<tbody>
<tr>
<td><strong>Calendar Year Deductible (CYD)</strong></td>
<td></td>
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<tr>
<td>Per Member</td>
<td>In-Network Only</td>
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<tr>
<td>Per Family</td>
<td>Does Not Apply</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>Does Not Apply</td>
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### Class I: Preventive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>In-Network</th>
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</thead>
<tbody>
<tr>
<td>Routine Oral Exam</td>
<td>0120</td>
<td>$0</td>
</tr>
<tr>
<td>Routine Cleanings (1 Every 6 Months)</td>
<td>1110/1120</td>
<td>$0</td>
</tr>
<tr>
<td>Bitewing X-rays (4 Films; 1 Series Every 6 Months)</td>
<td>0274</td>
<td>$0</td>
</tr>
<tr>
<td>Complete X-rays (1 Set Every 24 Months)</td>
<td>0210</td>
<td>$0</td>
</tr>
<tr>
<td>Fluoride Treatments (To Age 19; 1 Every 6 Months)</td>
<td>1206</td>
<td>$0</td>
</tr>
<tr>
<td>Sealants — Molars (Up To Age 15)</td>
<td>1351</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Emergency Care to Relieve Pain (During Regular Hours)</td>
<td>9110</td>
<td>$10 Copay</td>
</tr>
</tbody>
</table>

### Class II: Basic Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings (Amalgam; 3 Surf: Primary or Permanent)</td>
<td>2160</td>
<td>$0</td>
</tr>
<tr>
<td>Fillings (Composite, 3 Surf: Anterior/Posterior)</td>
<td>2332/2393</td>
<td>$0 Copay/$65 Copay</td>
</tr>
<tr>
<td>Deep Cleaning (1 Per Year)</td>
<td>4355</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Periodontal Maintenance (1 Every 6 Months)</td>
<td>4910</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Simple Extractions (Erupted Tooth / Exposed Root)</td>
<td>7140</td>
<td>$5 Copay</td>
</tr>
<tr>
<td>Surgical Removal of Tooth (Erupted / Impacted)</td>
<td>7210/7240</td>
<td>$45 Copay/$95 Copay</td>
</tr>
<tr>
<td>Root Canal Therapy (Molar)*</td>
<td>3330</td>
<td>$335 Copay</td>
</tr>
<tr>
<td>Local Anesthesia</td>
<td>9215</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Class III: Major Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowns (Porcelain Fused to High Noble Metal)</td>
<td>2750</td>
<td>$355 Copay</td>
</tr>
<tr>
<td>Dentures</td>
<td>5110/5120</td>
<td>$285 Copay</td>
</tr>
<tr>
<td>Bridges</td>
<td>6241</td>
<td>$255 Copay</td>
</tr>
</tbody>
</table>

### Class IV: Orthodontia (Lifetime Maximums) Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit — Child (To Age 19)</td>
<td>8070/8080</td>
<td>$1,900</td>
</tr>
<tr>
<td>Benefit — Adults and Dependent Children (Ages 19-25)</td>
<td>8090</td>
<td>$2,100</td>
</tr>
<tr>
<td>Evaluation</td>
<td>8660</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Records/Treatment Planning</td>
<td>8999</td>
<td>$100 Copay</td>
</tr>
<tr>
<td>Retention</td>
<td>8680</td>
<td>$275 Copay</td>
</tr>
</tbody>
</table>
Dental Insurance

Delta Dental PPO Plan

The City offers dental insurance through Delta Dental to benefit-eligible employees. The cost per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plans, please refer to Delta Dental’s benefit summary or contact Delta Dental’s customer service.

Dental Insurance – Delta Dental – Dental PPO Plan

<table>
<thead>
<tr>
<th>Classification 1 FT Employee</th>
<th>Tier of Coverage</th>
<th>26 Payroll Deductions – Per Pay Period Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Employee + 1 Dependent</td>
<td>$7.75</td>
<td></td>
</tr>
<tr>
<td>Employee + 2 or More Dependents</td>
<td>$18.57</td>
<td></td>
</tr>
</tbody>
</table>

In-Network Benefits

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

Out-of-Network Benefits

Out-of-network benefits are used when members receive services by a non-participating Delta Dental provider. Delta Dental reimburses out-of-network services based on what it determines is the Maximum Plan Allowance (MPA). The MPA is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member will pay the out-of-network benefit plus the difference between the amount that Delta Dental reimburses (MPA) for such services and the amount charged by the dentist. This is known as balance billing. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The dental PPO plan requires a $50 individual or a $100 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive and diagnostic services.

Calendar Year Benefit Maximum

The maximum benefit the dental PPO plan will pay for each covered member is $1,500 for in-network or out-of-network services combined. Diagnostic and Preventive services accumulate towards the benefit maximum.

Delta Dental | Customer Service: (800) 521-2651 | www.deltadentalins.com

Please Note: If a member is not able to use a Delta Dental PPO provider, then services can be received from a Delta Dental Premier Provider. Delta Dental Premier Providers are considered out-of-network dentists. These dentists have agreed to accept Delta Dental’s Maximum Plan Allowance (MPA) for each single procedure; however, the provider may still bill for the difference of the MPA and the Premier Dental Agreement amount. The member is responsible for verifying whether the treating dentist is a PPO Dentist or Premier Dentist.
# Delta Dental – Dental PPO Plan At-A-Glance

## Network

<table>
<thead>
<tr>
<th>Calendar Year Deductible (CYD)</th>
<th>Delta Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Member</td>
<td>In-Network</td>
</tr>
<tr>
<td>Per Family</td>
<td>$50</td>
</tr>
<tr>
<td>Waived for Class I Services?</td>
<td>Out-of-Network*</td>
</tr>
<tr>
<td></td>
<td>$100</td>
</tr>
<tr>
<td>Reminder: if using a Premier dentist balance billing may apply.</td>
<td></td>
</tr>
</tbody>
</table>

## Calendar Year Benefit Maximum

<table>
<thead>
<tr>
<th>Per Member (Includes Class I, II, &amp; III Service)</th>
<th>$1,500</th>
</tr>
</thead>
</table>

## Class I Services: Diagnostic & Preventive

- **Routine Oral Exam**
- **Routine Cleanings (2 Per Calendar Year)**
- **Bitewing X-rays (2 Per Calendar Year)**
- **Complete X-rays (1 Every 3 Years)**

- **Plan Pays: 100% Deductible Waived**
- **Plan Pays: 100% Deductible Waived (Subject to Balance Billing)**

## Class II Services: Basic Restorative

- **Fillings (Amalgam)**
- **Simple Extractions**
- **Deep Cleaning**
- **Endodontics (Root Canal Therapy)**
- **Periodontics**
- **Oral Surgery**
- **General Anesthesia (Limitations Apply)**

- **Plan Pays: 80% After CYD**
- **Plan Pays: 80% After CYD (Subject to Balance Billing)**

## Class III Services: Major Restorative

- **Crowns**
- **Dentures**
- **Bridges**

- **Plan Pays: 60% After CYD**
- **Plan Pays: 60% After CYD (Subject to Balance Billing)**

## Class IV Services: Orthodontia

- **Lifetime Deductible**
- **Benefit Maximum**
- **Benefit – Adults and Children**

- **$50 Per Member**
- **$1,000**
- **Plan Pays: 50% After CYD**
- **Plan Pays: 50% After CYD (Subject to Balance Billing)**

## Important Notes

- Each member may receive up to two (2) routine cleanings per calendar year under the preventive dental benefit.
- Waiting periods, age limits and plan limitations for certain services may apply.
Vision Insurance

EyeMed

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


#### 26 Payroll Deductions — Per Pay Period Cost

<table>
<thead>
<tr>
<th>Tier of Coverage</th>
<th>Employee Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$2.44</td>
</tr>
<tr>
<td>Employee + 1 Dependent</td>
<td>$4.63</td>
</tr>
<tr>
<td>Employee + 2 or More Dependents</td>
<td>$6.80</td>
</tr>
</tbody>
</table>

#### In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered employee and dependent(s) can select any network provider who participates in the EyeMed Insight network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan’s schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

#### Out-of-Network Benefits

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

#### Calendar Year Deductible

There is no calendar year deductible.

#### Calendar Year Out-of-Pocket Maximum

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

EyeMed | Customer Service: (866) 723-0513 | www.eyemed.com
# EyeMed – Vision Plan At-A-Glance

<table>
<thead>
<tr>
<th>Network</th>
<th>EyeMed – Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Materials</td>
<td>$10 Copay</td>
</tr>
</tbody>
</table>

**Frequency of Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>12 Months</td>
</tr>
<tr>
<td>Lenses</td>
<td>12 Months</td>
</tr>
<tr>
<td>Frames</td>
<td>24 Months</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>12 Months</td>
</tr>
</tbody>
</table>

**Lenses**

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>No Charge After Applicable Exam/Materials Copay</td>
<td>Up to $30 Reimbursement</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Up to $50 Reimbursement</td>
<td>Up to $70 Reimbursement</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Up to $70 Reimbursement</td>
<td></td>
</tr>
</tbody>
</table>

**Frames**

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic, Preferred or Non-Preferred</td>
<td>$110 Retail Allowance; Then a 20% Discount For Any Amount Over the Allowance</td>
<td>Up to $77 Reimbursement</td>
</tr>
</tbody>
</table>

**Contact Lenses**

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Elective (Medically Necessary)</td>
<td>No Charge</td>
<td>Up to $210 Reimbursement</td>
</tr>
<tr>
<td>Elective (Fitting, Follow-up &amp; Lenses)</td>
<td>$110 Allowance</td>
<td>Up to $110 Reimbursement</td>
</tr>
</tbody>
</table>

## Locate a Provider

To search for a participating provider, contact EyeMed’s customer service or visit www.eyemed.com. When completing the necessary search criteria, select *EyeMed Insight* network.

## Plan References

*Contact lenses are in lieu of spectacle lenses.*

## Important Notes

- Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.
**Flexible Spending Account**

The City of Miramar offers Flexible Spending Accounts (FSA) administered through AmeriFlex. The FSA plan year is from January 1 to December 31.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employee to set aside money from their paycheck for reimbursement of health care and day care expenses that they regularly pay. The amount set aside is not taxed and is automatically deducted from the employee’s paycheck and deposited into the FSA. During the year, the employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount they wish to have deducted each plan year.

The City offers two types of FSAs:

- **Health Care Reimbursement FSA**: The Health Care FSA covers medical, dental, and vision expenses that are not paid by insurance.
- **The Dependent Care FSA**: Available to eligible employee for qualified dependent day care expenses that are necessary for employee and legal spouse, if married, to work.

<table>
<thead>
<tr>
<th>Health Care FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>This account allows participants to set aside up to an annual maximum of $2,650. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). Examples of common expenses that qualify for reimbursement are listed below.</td>
<td>This account allows participant to set aside up to an annual maximum of $5,000 if single or $2,500 if married and file a joint tax return, for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults. Please note that if a family’s income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be: - A child under the age of 13, or - A child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in the participant’s household.</td>
</tr>
</tbody>
</table>

**Please Note:** The entire Health Care FSA election is available for use on the first day coverage is effective.  
**Please Note:** Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from the participant’s paycheck for the Dependent Care FSA.

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

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

Flexible Spending Account  

(Continued)

**FSA Guidelines**

- The Health Care FSA allows a grace period at the end of the plan year (January 1 – March 15). The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends.
- The Health Care FSA has a run out period at the end of the year (to March 31) to submit for reimbursement on eligible expenses incurred during the period of coverage within the plan year and grace period.
- When a plan year and grace period ends and all claims have been filed, all unused funds will be forfeited and will not be returned.
- Employee can enroll in either or both of the FSAs only during the open enrollment period, a qualifying event, or new hire eligibility.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses which are reimbursed through an FSA.
- Domestic Partners are not eligible as federal law does not recognize them as a qualified dependent.

**Filing a Claim**

**Claim Form**

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

**Debit Card**

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities and most pharmacy retail outlets. AmeriFlex may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to AmeriFlex. This card will not expire at the end of the benefit year. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

**HERE’S HOW IT WORKS!**

An employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $38.46 based on a 26 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

<table>
<thead>
<tr>
<th></th>
<th>With a Health Care FSA</th>
<th>Without a Health Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>FSA Contribution</td>
<td>- $1,000</td>
<td>- $0</td>
</tr>
<tr>
<td>Taxable Pay</td>
<td>$29,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Estimated Tax</td>
<td>- $6,568</td>
<td>- $6,795</td>
</tr>
<tr>
<td>22.65% = 15% + 7.65% FICA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After Tax Expenses</td>
<td>- $0</td>
<td>- $1,000</td>
</tr>
<tr>
<td>Net Income</td>
<td>$22,432</td>
<td>$22,205</td>
</tr>
<tr>
<td>Tax Savings</td>
<td>$227</td>
<td></td>
</tr>
</tbody>
</table>

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

**AmeriFlex | Customer Service: (888) 868-3539 | www.myameriflex.com**
Basic Life and AD&D Insurance

Basic Term Life

The City provides a Basic Term Life benefit through The Standard at no cost to employee.

Class 1: City Managers will receive a coverage amount of 1.5 times their annual salary with a maximum of $330,000.

Class 2: Unrepresented employees will receive a coverage amount of 1.5 times their annual salary with a maximum of $280,000.

Class 3: IAFF employees will receive a coverage amount of 1 times their annual salary with a maximum of $100,000.

Class 4: PBA employees will receive a coverage amount of 1 times their annual salary with a maximum of $100,000.

Class 5: GAME employees will receive a coverage amount of 1.5 times their annual salary with a maximum of $150,000.

Class 6: Part-Time employees will receive a coverage amount of $5,000.

Please Note: Employees, who do not smoke, will also be eligible for an additional $20,000 benefit at no cost.

Accidental Death & Dismemberment

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

Voluntary Life Insurance

Voluntary Employee Life

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

New Hires can purchase voluntary employee life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $50,000.

• Units can be purchased in increments of $10,000, not to exceed a maximum of $500,000.
• Benefit amounts for Class 1, 2 and 6 are subject to the following age reduction schedule:
  › 67% at age 65
  › 45% at age 70 or over

Voluntary Spouse Life Insurance

New Hires can purchase voluntary spouse life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $25,000.

• Employees must participate in the employee voluntary plan for spouse to participate.
• Units can be purchased in increments of $5,000, not to exceed a maximum of $250,000.
• The spouse coverage cannot exceed 50% of the employee’s voluntary life coverage amount.
• Spouse life insurance coverage is subject to the following age reduction schedule, as the spouse ages:
  › 67% at Age 65
  › 45% at Age 70

Always remember to keep beneficiary forms updated. Employee may update beneficiary information at anytime through the Human Resources Department or by logging onto BenTek at www.mybentek.com/cityofmiramar.
Voluntary Life Insurance (Continued)

Voluntary Life Monthly Rates

<table>
<thead>
<tr>
<th>Age Bracket</th>
<th>Employee/Spouse (Per $1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 29</td>
<td>$0.054</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.072</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.090</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.153</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.261</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.414</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.612</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.900</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.422</td>
</tr>
<tr>
<td>70-74</td>
<td>$2.934</td>
</tr>
<tr>
<td>&gt; 75</td>
<td>$5.022</td>
</tr>
</tbody>
</table>

Dependent Child(ren) Life Insurance
- Employee must participate in the employee voluntary plan in order for dependent children to participate.
- The dependent’s coverage may not exceed 50% of the employee’s voluntary life coverage amount.
- For eligible unmarried children, from birth to age 20, or to age 24 if a full-time student, employee can select from 3 benefit amounts:
  - Option 1: $1,000
  - Option 2: $5,000
  - Option 3: $10,000
- Coverage is a flat $0.045 per month per $1,000 for any eligible dependent children enrolled, regardless of how many.

Monthly Premium Calculation: Elected coverage ÷ $1,000 x Employee rate (see table above) x 12 months ÷ 26 annual deductions = payroll deduction

Long Term Disability Insurance
The City provides a Long Term Disability (LTD) insurance, at no cost, to benefit-eligible employees through The Standard. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness, non-work related accident, or injury. Eligible employee is automatically enrolled in this coverage.

Class 1: Non-Union Management members other than the Non-Union Safety Management members.

Class 2: Non-Union Safety Management members.

Class 3: Union member other than the Safety Management members.

Class 4: Union Safety members.

LTD Plan Summary
- Classes 1 and 2 employees receive an LTD benefit of 50% of monthly earnings to a maximum benefit of $5,000 per month.
- Classes 3 and 4 employees receive an LTD benefit of 60% of monthly earnings to a maximum benefit of $5,000 per month.
- The benefit will begin on the 91st day following the occurrence of the disabling event (known as the elimination period).
- If employee returns to work part-time, a partial LTD benefit may be payable.
- Classes 1 and 3 employees will continue to receive benefits for 24 months if unable to return to their own occupation.
- Classes 2 and 4 employees will continue to receive benefits for 12 months if unable to return to their own occupation.
- The duration the LTD benefit is payable based on your age at the time the disabling event occurs.
- Periodic evaluations may occur at the discretion of The Standard.

The Standard | Customer Service: (800) 368-1135 | www.standard.com
Supplemental Insurance

The City offers a variety of voluntary supplemental insurance through Aflac, that may be purchased separately on a voluntary basis and premiums paid by payroll deduction on an after-tax basis, for most products. To learn more about these plans and/or to schedule a personal appointment, contact your local Aflac agent. Details regarding available plans and services are also available online at www.aflacgroupinsurance.com.

Available plans include coverages for:

**Group Short Term Disability**
- Covers disabilities due to non-occupational injuries or illness. Pregnancy covered as any other illness.
- Provides a tax-free income replacement up to an elected percentage of pre-disability earnings.
- Provides coverage for up to three (3) months of disability.
- Benefits payments begin immediately for injuries or on the eighth day for illness.

**Group Whole Life Insurance**
- Provides a death benefit to listed beneficiaries.
- Accumulates tax-deferred cash values.

**Group Critical Illness**
- Pays a lump sum from $5,000 to $50,000 for the first diagnosis of a covered Critical Illness. Conditions include: Cancer, Heart Attack, Stroke, Major Organ Transplant and Renal Failure (Kidney Disease). A wellness benefit is also payable annually. Contact the Human Resources Department for additional information regarding this benefit.

**Group Accident**
- Pays cash benefits for expenses resulting from on or off-the-job injuries and pays in addition to any other insurance in force.
- Pays for sprains, burns, fractures, dislocations, hospital stays, doctor’s office visits, as well as other plan benefits.
- Wellness benefits are also payable annually.

**Group Hospital Indemnity**
- Pays cash benefits directly to the insured for hospital confinements due to injury, illness, or pregnancy - pays in addition to any other coverage in force.
- Pays for outpatient surgeries.
- Pays for physician office visits for both well visits and sick visits.
- Wellness benefits are also payable annually. Contact the Human Resources Department for additional information regarding this benefit.

Aflac | Customer Service: (800) 433-3036 | www.aflacgroupinsurance.com

Agent: Margaret Pearson | Phone: (561) 881-1964
Email: margaret_pearson@us.aflac.com
Employee Assistance Program

The City offers at no cost an Employee Assistance Program (EAP) to benefit-eligible employees and family members through Aetna. Aetna's Resources for Living Employee Assistance Program provides employee and family member(s) with professional counseling for a variety of problems that affect quality of life. All EAP counselors are professionally trained and are certified/licensed in their fields. Qualified counselors are available 24 hours a day, 7 days a week, at (888) 238-6232. The EAP also allows for three (3) face to face in-person sessions with a counselor for short-term problem resolution. Conditions that require a long-term treatment solution may be referred to employee’s medical plan.

What is an Employee Assistance Program?

The City cares about employee’s well-being on and off the job and provides an EAP to give employee’s a comfortable, safe place to turn for help with problems such as:

- Relationship Issues
- Substance Abuse
- Critical Incident Stress Debriefing
- Childcare Consultation
- Eldercare Consultation
- Marital Problems
- Financial and Legal Issues
- Stress Management
- Parenting Problems
- Identity Theft

Are your services confidential?

Yes. Receipt of EAP services is completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), we will ask permission to communicate certain aspects of the employee’s care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor will not, however, receive specific information regarding the referred employee’s case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

UHC Travel Assistance

United Healthcare Global Assistance is a free service offered through the Basic Life Insurance. It is a comprehensive program of information, referral, assistance, transportation and evacuation services designed to help member respond to medical care situations and many other emergencies that may arise during travel.

UHCTravel Assistance | Customer Service: (800) 527-0218
Email: assistance@uhcglobal.com

Legal Services

Employees have the opportunity to enroll in a voluntary pre-paid legal program through Preferred Legal Plan. By enrolling in this plan, a participant will have 24-hour direct access to attorneys who will provide a variety of legal assistance and services such as those listed below. Additional services may also be provided at discounted rates.

Preferred Legal Plan includes, but not limited to:

- Free unlimited legal advice via phone consultation
- Free face-to-face consultations with attorneys
- Free review of legal documents (real estate contracts, lease agreements, simple Wills, etc.) and notary services
- Free letters and phone calls on your behalf to third parties
- Free Identity Theft information and restoration
- Free access to legal forms

The cost to the employee to participate in this legal plan is $4.60 per pay period. This cost is the same for all employees regardless of the number of eligible dependents enrolled in the plan. All premiums will be payroll deducted on a post-tax basis for your convenience.

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

Aetna | Aetna Resources for Living
Customer Service: (888) 238-6232 | www.mylifevalues.com
Username: City of Miramar | Password: eap
Wellness with Aetna Healthy Commitments℠ Program

The City of Miramar is devoted to health and wellness and continues to embrace health plans that inspire employees and their dependents to take Simple Steps To A Healthier Life®.

The goal of the City is to provide a wellness program that will engage and encourage employees to be healthy and to provide tools and educational programs that will help us achieve our wellness goals.

We are all very excited to continue our mission to bring the employees of the City of Miramar the best educational programs, disease management programs, fitness programs and the best overall wellness program in the state!

Our partners at Aetna give employees the tools to stay on track with the Aetna Healthy Commitments℠ Program. With the Healthy Commitments℠ Program, you take the first steps toward a new, healthier you. The program includes a Personal Health Assessment, Online Wellness Programs, 24/7 Nurseline, Online Resources, Discount Programs (i.e. fitness, natural products, etc.), Incentive Reporting, Challenges and Much More!

We encourage all of our City employees to participate in the wellness program. Please watch for upcoming health and wellness events and join us in becoming one of the healthiest cities in Florida!

Retirement Plans

The City has several retirement programs available for benefit eligible employees. Defined Benefit Pension Plan, and a Deferred Compensation Plan (457) – available to help prepare for your future. Eligibility is based upon your employment status. For additional information on these programs, please contact the Human Resources Department.

Deferred Compensation Plan (457)
2018 Tax Year Contributions:
- Contribution limit is $18,500
- $24,500 if age 50 or older at year end

Defined Benefit Pension Plan
A Defined Benefit Pension Plan is a type of retirement plan in which an employer/sponsor promises a specified monthly benefit at retirement that is predetermined by a formula based on employee earnings history, tenure of service and age, rather than depending directly on individual investments return.

Employee Claims Resource

Do you have a question about how a medical claim was paid?
Are you receiving bills from your provider and not understanding why?
Do you want a better understanding of how your benefits work?

The City of Miramar has worked with the Aetna’s Team to come up with a solution! We are excited to announce that Aetna has a team of claims specialists to assist employee’s with these concerns.

Please Contact:
Aetna Claims Support
(855) 281-8858

Follow the prompts, be sure to identify yourself as an employee of the City of Miramar and ask to speak to a Claims Specialist. You will be immediately directed to an Aetna Claims Specialist who will be more than happy to help you.

Office hours are Monday through Friday from 8:00 am – 6:00 pm EST.
Notes
Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctor’s names and addresses or prescription medications.
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