City of Ocala

EMPLOYEE BENEFIT GUIDE

October 1, 2024 through September 30, 2025

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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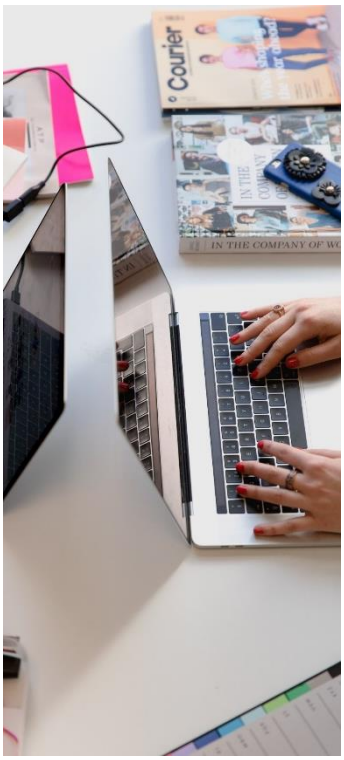
WELCOME



The City of Ocala is committed to providing our employees with a comprehensive benefits program to help you stay healthy and feel secure. This booklet will describe those benefits which include Medical, Dental, Vision, Life/AD&D, Voluntary Life, Disability and other Voluntary coverage. For a detailed description of these benefits please refer to the applicable Certificates of Coverage.

ANNUAL OPEN ENROLLMENT

During the annual open enrollment period, you may make changes to your benefit plan elections and/or the family members you cover. Changes can only be made outside of the annual enrollment period if you experience a qualified life event. Now is the time to carefully review your plan options. Open Enrollment for our benefit plans will be conducted July 17th through July 31st. Elections you make during open enrollment will become effective October 1, 2024.

WHAT'S NEW FOR 2024-2025

Medical insurance is renewing with FL Blue

- Network will remain Blue Options
- No change in rates

Dental insurance is renewing with Florida Combined Life

- No change in rates

Vision Insurance is renewing with Standard

- No change in rates

Life Insurance is renewing with Minnesota Life

- No change in voluntary life rates

Short- and Long-Term Disability Insurance are renewing with MetLife

- No change in rates

Health and Wellness Center

- Premise Health now offers a website dedicated to the City of Ocala where employees can find information about services offered at the Health and Wellness center.

WHO WE COVER

Employees are eligible to participate in the City of Ocala employee benefits program:

- if they work 30 or more hours a week. Coverage will be effective 1st of the month following 30 days of employment.

Dependent Eligibility

A dependent is defined as the participant's legal spouse, or child(ren) (natural, newborn, adopted, foster or step) or for whom the participant has been court-appointed as legal guardian/custodian. Dependent children may be covered as follows:

- Medical
  - ❑ To end of the calendar year following their 30th birthday
- Dental
  - ❑ To end of the calendar year following their 30th birthday
- Vision
  - ❑ through the end of the year they turn 26 for whom the insured or insured's spouse is legally responsible
- Voluntary Life and Worksite
  - ❑ To age 26

QUALIFIED LIFE EVENTS

Premiums for medical, dental, and vision insurance 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 your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

• Marriage	• Divorce or legal separation (subject to State regulations)
• Death of spouse, child or other qualified dependent	• Birth, gain legal custody or adoption of child
• Gain or loss of other group coverage (including Medicare coverage)	• Change in employment status for employee, spouse or dependent
• Change in residence due to an employment transfer	• Change of dependent status
• An increase or decrease in your work hours causes eligibility or ineligibility	• Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60-day notification period).

IMPORTANT

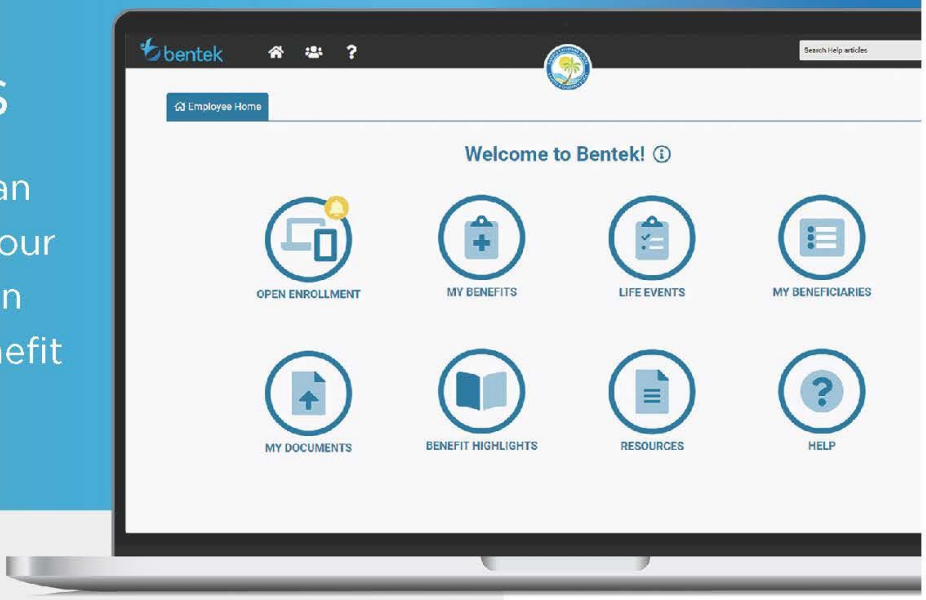
If you experience a qualifying event, **you must contact Human Resources within 30 days of the qualifying event** to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied, and the employee may be responsible both legally and financially for any claim and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. You will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

BENTEK ONLINE BENEFITS ENROLLMENT SYSTEM

bentek
BENEFITS TECHNOLOGY

Quick Tips

Bentek is easier than ever to access all your benefits information and make your benefit elections!



The City of Ocala provides Bentek, an internet based online benefits enrollment system, available 24 hours a day, 7 days a week.

ACCESSING BENTEK

1. Log on to **www.mybentek.com/cityofocala**
2. Click on "Don't have an account? Create one"
3. Follow directions to create your Username and Password
   Please Note: password must contain three (3) of the following:
   - **Lowercase Letter**
   - **Capital Letter**
   - **Number**
4. Click the "Menu" options in the upper left screen or click the navigation icons on your home page.

LAUNCHPAD

- ✓ **Open Enrollment** – Click to start your Open Enrollment Session
- ✓ **New Hire Enrollment** – Click to start your new hire session
- ✓ **Life Events** – Click to report a qualifying life event
- ✓ **My Benefits** – Click to view current elections and payroll deductions
- ✓ **Benefit Highlights** – Click to view plan descriptions and carrier information
- ✓ **Forms** – Click to view plan documents and frequently used forms
- ✓ **My Beneficiaries** – Click to add, change or update beneficiary information
- ✓ **My Documents** - Click to upload documents and submit for review

IMPORTANT NOTES

- Bentek is accessible on desktop, tablets, smartphones or anywhere internet connectivity is available
- For security purposes, Bentek will time out after 15 minutes of inactivity. An alert will appear providing the option to refresh the session time or log out.
- If you have trouble accessing Bentek, please contact the Bentek Support Line at: support@mybentek.com, or (888) 5-Bentek (523-6835) Monday – Friday, 8:30am – 5:00pm EST

To access Bentek using a mobile device, scan code.

877.523.6835 | mybentek.com | support@mybentek.com

HOW TO ENROLL

bentek
BENEFITS TECHNOLOGY

Bentek Enrollment Quick Guide

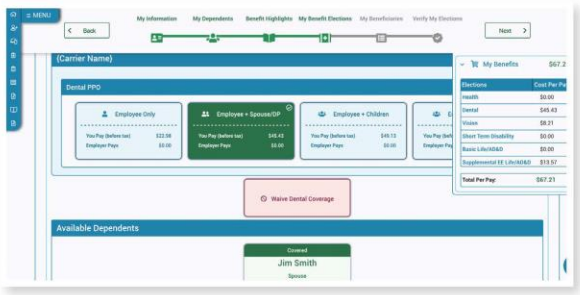
START YOUR ENROLLMENT SESSION!

- ✓ Log on to **www.mybentek.com/cityofocala**
- ✓ View your current elections, deduction amounts, covered dependents, and beneficiaries.
- ✓ Click "Make No Changes" to submit your session as shown under My Elections.
- ✓ Click "I Want To Make Changes" to start your enrollment session.

To access Bentek using a mobile device, scan code.

ENROLLMENT IN SIX EASY STEPS

1. **My Information** – Verify your demographic information is correct.
2. **My Dependents** – Verify your current dependent information.
   - › **Add a new dependent by clicking "+ Dependent"**
3. **Benefits Highlights** – Enrollment news, coverage options, plan documents and carrier information.
4. **My Benefit Elections** – Add/remove/change plans, add/remove dependents, and track per-pay deductions in your Benefits Cart.
   - › **Selected plans and covered dependents will show in green.**
5. **My Beneficiaries** – Add, remove, or change beneficiary information.
   - › **Add a new beneficiary by clicking "+ Person" or "+ Trust"**
6. **Verify My Elections** – Review enrollment elections and submit your session.
   - › **Life insurance requiring carrier approval will show as pending.**



877.523.6835 | mybentek.com | support@mybentek.com

MEDICAL INSURANCE TERMS

Coinsurance
Coinsurance is the percentage of the medical services you are responsible to pay after the deductible has been met. Once you have met your deductible for the plan year, you pay the coinsurance amount up to the out-of-pocket maximum.

Copay
A fee you pay every time you get medical care or a prescription. Copays can vary based on where you get care.

Deductible
A deductible is the amount of money you must pay before the plan begins paying benefits for specified services. Deductibles do not apply to all services- see summary plan description for application.

Embedded Deductible
Plan begins paying benefits that require cost sharing for the first family member who meets the per-person deductible. Once one or more of the remaining family members meet the family deductible the plan pays benefits for all covered family members.

Explanation of Healthcare Benefits (EOB)
A letter you receive after getting care that shows costs, the amount the health plan is expected to pay and the amount you are expected to pay. You do not pay anything when you receive an EOB.

Non-Embedded Deductible
When the family deductible is met the plan beings sharing costs for each member. The deductible can be met by one or combination of family members.

Out-of-Pocket Maximum
The out-of-pocket maximum is the maximum amount you will pay, inclusive of copayments/coinsurance and deductibles for covered services, in a plan year. Once you have reached the out-of-pocket maximum during a policy year the plan pays any remaining eligible services at 100%.

Premium
Your regular payment to your health plan. Generally, a higher premium means lower monthly out-of-pocket costs, and a lower premium means higher out-of-pocket costs. Your premium does not count towards your deductible or out-of-pocket maximum.

Plan Milestones and Stages

1. When your plan begins, you're in the first stage. You pay for all your covered medical costs until you hit the **deductible**.
2. After hitting your deductible, you enter the next stage. You now pay only a percentage of your medical costs and the health plan pays the rest. This is the **coinsurance** stage of your plan.
3. The coinsurance stage lasts until you reach the **out-of-pocket** maximum. At that point, the plan starts paying for all covered medical costs for the rest of the plan year.

MEDICAL INSURANCE TERMS

In-Network

In-network refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider because those networks provide services at lower cost to the insurance companies with which they have contracts. Example: You go to a doctor and the total charge is $250. You will receive a discount of $75 because you went to an in-network doctor and the negotiated rate with the doctor is lower. The insurance company pays $155. You pay what's left, which is $20.

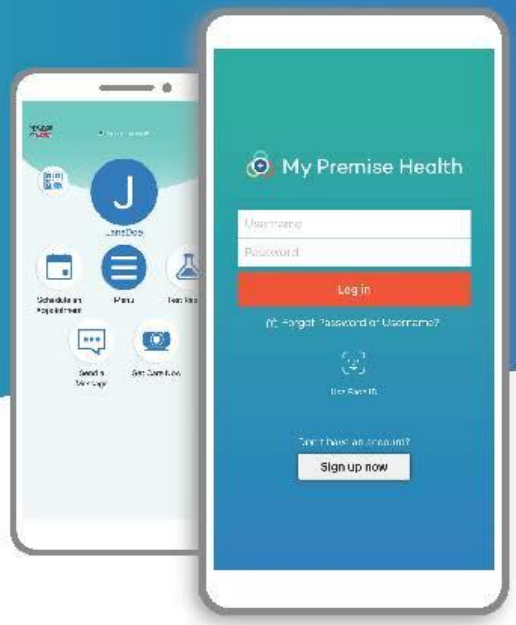
Out-of-Network

Out-of-network refers to physicians, hospitals or other health care providers who are considered nonparticipants in an insurance plan or network. Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-network health professionals may not be covered or covered only in part by the individual's insurance company. Example: You go to a doctor and the total charge is $250. You will not receive a discount because the doctor is out-of-network. The insurance company still pays $155, but you'll be responsible for what's left, which is $95.

HEALTH RISK ASSESSMENT WELLNESS INCENTIVE

Health Risk Assessment 101

Prioritize your preventive care.



What is an HRA?

A health risk assessment (HRA) is a type of preventive care recommended to better understand your health and wellbeing. An HRA includes a health questionnaire, bloodwork and vital sign screening to measure your cholesterol levels, nutrition, liver function, chemistry levels and more. It can identify the potential risk of diabetes, hypertension and other health concerns that could become more serious if not detected early.

Complete your HRA and provider Follow-up by **September 30th** to be eligible for the Wellness Incentive. Outside provider forms are also accepted until September 30th. Please contact HR at 352-629-8359 to obtain outside provider forms.

Schedule your appointment to get started.

352-663-9156

Create or sign into your account on mypremisehealth.com or through the app. Select "Schedule an Appointment," then "Biometrics." You can then complete your health questionnaire during eCheck-In or when you arrive for your lab appointment.

Employees and dependent spouses enrolled in a "With Wellness" health insurance plan must complete the HRA and follow-up appointment by September 20th of each year. The HRA provides a current evaluation of your overall health through a 28-panel blood draw, vitals, and health and behavior questionnaire.

Who can use these services?
Services are available to all employees, dependents, spouses and retirees covered by the city's health insurance plan.

Premise Health. Wellness Center | OCALA

FLORIDA BLUE MEDICAL INSURANCE

Network: BlueOptions

Website: www.floridablue.com

Medical Plan Highlights	PPO 03359	
	PPO Network	Non-Network
Annual Deductible	$1,500/ $3,000 (Family)	$1,500/ $3,000 (Family)
Coinsurance	30%	50%
Annual Out of Pocket Maximum (Includes Deductible & Copays)	$3,000/ $6,000 (Family)	$5,000/ $10,000 (Family)
Preventive Care	Covered 100%	Covered 100%
Virtual Visit (PCP/Specialist)	$30 copay/ $60 copay	Not covered
Office Visit (PCP/Specialist)	$30 copay/ $60 copay	Deductible + Coinsurance
Outpatient Surgery	Facility Fee: $100 copay (ASC), $150 copay (Hospital), Physicians Fee: Deductible + Coinsurance	Deductible + Coinsurance
Inpatient Hospitalization	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room (Facility Only)	$300 copay	$300 copay
Urgent Care	$35 copay	Deductible + $35 copay
Lab/X-Ray	Independent Lab $0, Diagnostic Test Center $50 copay, $200 copay	Deductible + Coinsurance
Advanced Imaging (CT, PET,MRI)	$200 Copay	Deductible + Coinsurance
Prescription Drugs Tier 1 Tier 2 Tier 3	Rx Deductible Applies $10 copay $30 copay $45 copay	50% Coinsurance
Mail Order Prescription Tier 1 Tier 2 Tier 3	Rx Deductible Applies $20 copay $60 copay $90 copay	50% Coinsurance

	With Wellness Incentive	No Wellness Participants	One Wellness Participant
Single	$57.68	$82.14	N/A
Family	$275.86	$327.36	$287.62

For limitations & exclusions, please refer to certificate of coverage or benefit summary.

FLORIDA BLUE MEDICAL INSURANCE

Network: BlueOptions

Website: www.floridablue.com

Medical Plan Highlights	PPO 05902	
	PPO Network	Non-Network
Annual Deductible	$2,500/ $5,000 (Family)	$2,500/ $5,000 (Family)
Coinsurance	20%	50%
Annual Out of Pocket Maximum (Includes Deductible & Copays)	$5,000/ $10,000 (Family)	$10,000/ $10,000 (Family)
Preventive Care	Covered 100%	Coinsurance
Virtual Visit (PCP/Specialist)	$40 copay/ $100 copay	Not Covered
Office Visit (PCP/Specialist)	$40 copay/ $100 copay	Deductible + Coinsurance
Outpatient Surgery	Facility/ Physician Fees: Deductible + Coinsurance	Deductible + Coinsurance
Inpatient Hospitalization	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room (Facility Only)	Deductible + Coinsurance	Deductible + 20% Coinsurance
Urgent Care	$45 copay	Deductible + $45 copay
Lab/X-Ray	Independent Lab: $0, Diagnostic Test Center: Deductible + Coinsurance	Deductible + Coinsurance
Advanced Imaging (CT, PET,MRI)	Deductible + Coinsurance	Deductible + Coinsurance
Prescription Drugs Tier 1 Tier 2 Tier 3	Rx Deductible applies $20 copay $40 copay $60 copay	50% Coinsurance
Mail Order Prescription Tier 1 Tier 2 Tier 3	Rx Deductible applies $40 copay $80 copay $120 copay	50% Coinsurance

	With Wellness Incentive	No Wellness Participants	One Wellness Participant
Single	$11.04	$33.08	N/A
Family	$182.88	$222.58	$193.08

For limitations & exclusions, please refer to certificate of coverage or benefit summary.

ELECT RX MAIL ORDER PHARMACY

ELECT Rx
Pharmacy Benefit Strategists

The City of Ocala
International Mail Order Program

How to Use the Elect RX International Mail Order Program

The City of Ocala is offering a great option for you to save money on certain **brand name** prescription drugs through the **Elect Rx International Mail Order Program**. This program is known as Personal Importation or PI. You can order your brand name drugs from Canada, New Zealand, Australia and England using the same "brick and mortar" pharmacies that people in these countries use for their medications. Plan Members will have a **$0 co-pay (Free!)** on these medications for their **first** fill. All subsequent refills through this program will only have a **$10 co-pay**. Plan Members with FSA accounts cannot use the FSA account for reimbursement because of IRS rules. Here's how you can begin using the program.

1. On the back of this document is a list of brand name prescription drugs that are offered through the Elect Rx Personal Importation Program (PI). Review this list and see if any of the medications you are currently taking can be filled through the Personal Importation (PI) Program. **Elect Rx never does a first fill so you must have been on this drug for at least 30 days prior to entering the program.** We are constantly updating this list. Call Customer Service if you do not see your drug listed. You can order a 90-day supply of most brand name medications that are eligible for dispensing through this program.
2. Members can enroll by calling **1-855-353-2879**. A Customer Service Representatives will complete the enrollment process and order for you. You will be asked several questions related to your medical condition including any known allergies and a list of the prescription drugs you are currently taking. **You should have those prescription drugs with you when you make the call.**
3. Have your Physician prepare a prescription for a **90-day supply** with **3 refills** and FAX it to the Elect Rx Toll Free Number at **1-833-353-2879**. Again, you have a **$0 co-pay** on each 90-day fill including subsequent refills. You will receive an automated reminder notification of a pending renewal/refill on or around day 60 of the last 90-day supply shipped. Shipping takes 10-15 business days from the date of completed requirements (Faxed Rx from Physician and initial call to customer service from the member /employee). Specialty drugs are usually 30-day supplies. **Tip: Have a 30-day supply on hand to allow for plenty of delivery time.**

Elect Rx Customer Service: 1-855-ElectRx
(Monday-Friday 8:30AM-4:30PM Eastern Time)

Elect Rx Physician Fax: 1-833-ElectRx

Customer Service Email: info@electrx.com

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WHERE TO GO WHEN SEEKING MEDICAL ATTENTION

Do not pay more than you must for medical care. The emergency room is meant for emergencies such as life threating illnesses and injuries. Walk-in-clinics are designed to treat common ailments, provide basic primary health care, and are typically staffed by nurse practitioners and sometimes a physician's assistant. Urgent care facilities are designed to treat patients who are suffering from acute, non-life-threatening illnesses and injuries that are beyond the capacities of a regular walk-in-clinic and are typically open for extended hours. To maximize savings, use in-network facilities.

Reasons to see your Primary Care Physician:

Chronic Conditions such as:

- Hypertension/High Blood Pressure
- Diabetes/High Blood Sugar
- High cholesterol
- Heart disease
- Arthritis
- Depression

Acute Conditions such as:

- Headache and/or fever
- Urinary tract infection
- Minor injuries
- Back, neck, shoulder, knee and/or hip pain

Benefits of visiting your PCP:

- Low copay
- Medical history is available
- Established relationship with your doctor and clinical staff

Reasons to use a Virtual Visit:

- Cough, cold or flu
- Minor strains & sprains
- Bronchitis & sinus infection
- Skin & eye issues
- Upset stomach
- Urinary tract/bladder infections
- Rashes
- Pink eye
- Pediatric issues
- Psychological issues
- Visit with a licensed therapist

Benefits of virtual visits:

- 24/7 access to care
- Low copay
- Board certified physicians
- Nationwide network
- Available on smartphone or tablet
- Use when PCP, Urgent care or Extended Hour Care Center are unavailable to you

Reasons to visit an Urgent Care:

- Acute minor trauma
- Cough, cold or flu
- Upper respiratory infections
- Strains, sprains & fractures
- Minor allergic reactions and asthma attacks
- Immunizations
- Back, neck, shoulder, knee and/or hip pain
- Minor lacerations, burns and other small wounds
- Urinary tract/ bladder infections

Benefits of urgent care visits:

- Low copay
- Shorter wait time
- Same-day appointments
- Significant savings over ER

Reasons to visit the Emergency Room:

- Any life-threatening emergency
- Any severe illness or injury
- Unresponsiveness
- Chest pain
- Weakness on one side
- Inability to speak
- Spine or head injury
- Change in mental status
- Difficulty breathing
- Uncontrolled bleeding
- Poisoning
- Severe abdominal pain

EMPLOYEE HEALTH & WELLNESS CENTER

Overview

The Premise Health Employee Health and Wellness Clinic is available at no cost to all City health insurance plan members, age 8 and older. Overall, the City's self-insured health insurance experiences significant savings when compared to what those services would have cost in the private market. Services offered include:

- Primary Care
- Chronic Disease Management
- Lab, X-Ray and Bloodwork
- Generic Rx Medications
- Health and Wellness Coaching

New Account Registration

When registering a new account on ***mypremisehealth.com***, employees are given a default login. The username is first initial + last name (no spaces) and the password is the last 6 digits of employee social security number. The access code for adding dependents is **OCALA3**.

Annual Health Assessment (AHA)

Employees and dependent spouses enrolled in a "With Wellness" health insurance plan must complete the AHA and follow-up appointment by September 30th of each year. The AHA provides a current evaluation of your overall health through a 28-panel blood draw, vitals, and health behavior questionnaire.

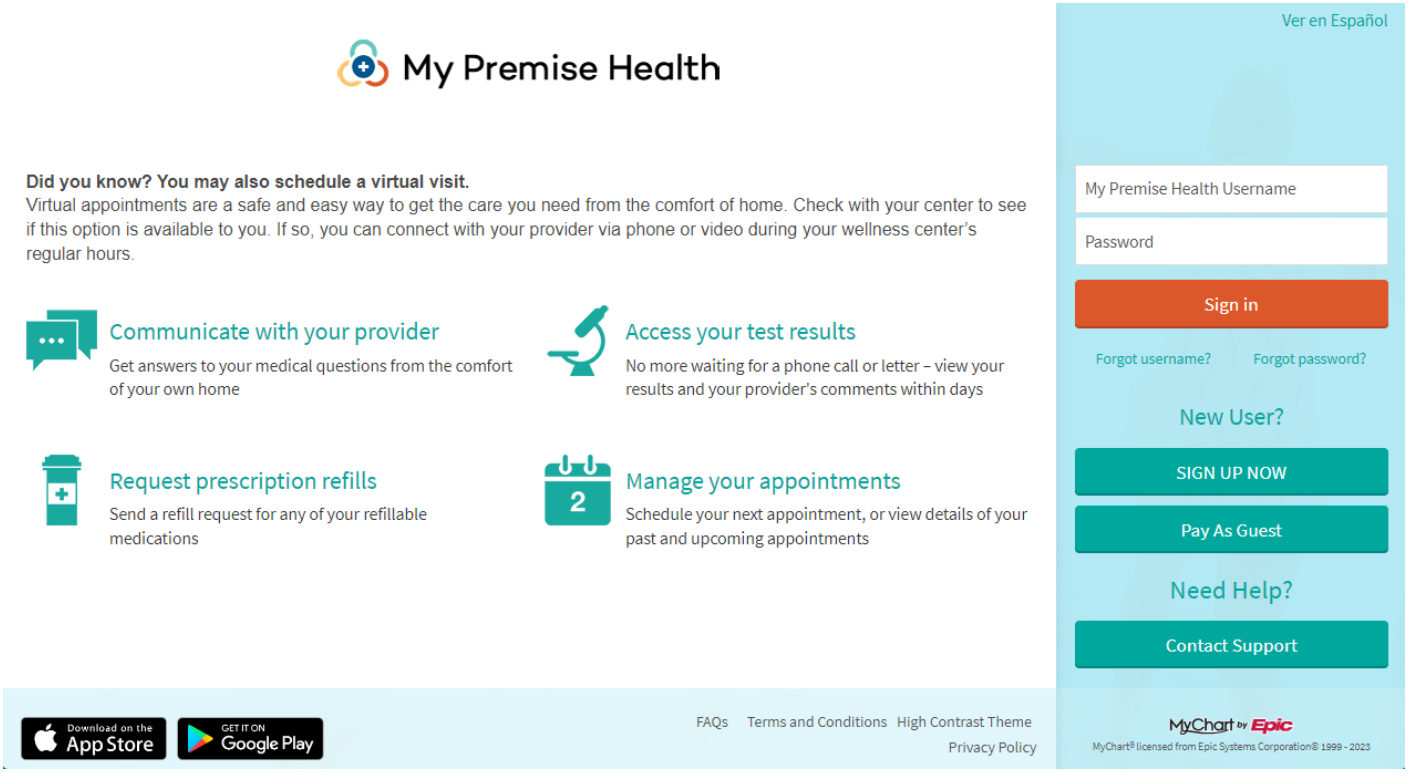
No Show Policy and Fee

The Premise Health Clinic operates like a normal medical office and relies on members keeping their appointments and arriving on time. An employee or retiree will be assessed a $25 surcharge if he/she, or their eligible dependent, has more than two instances of: not showing up for a scheduled appointment, not canceling an appointment at least one hour prior to the scheduled appointment time, and/or is more than ten minutes late to an appointment.

Hours

(Closed daily for lunch from 12 – 1pm)

Mon & Thurs	7am – 5pm
Tues & Wed	7am – 6pm
Fri	8am – 5pm



EMPLOYEE HEALTH & WELLNESS CENTER

As a City of Ocala employee, you now have access to a dedicated Premise Health website where you can find information about services offered at the City of Ocala Health & Wellness Center.

Here's what you'll find
The new website is designed with you in mind. Easily scroll through various sections to find the information you need, without the hassle.

Personalized health resources.
Access personalized health resources and tools available for your unique needs.

Available services.
Get information about the convenient services available to you as a City of Ocala employee, including primary care, women's health, preventive checkups, prescription delivery and more.

Appointment scheduling.
The website easily connects you to your patient portal, My Premise Health, where you can create your account and schedule appointments.

Need-to-know info.
Find the wellness center address, hours of operation, important dates and wellness information.

Learn more about the health & wellness center, services offered and your experienced providers.

Visit members.premisehealth.com/city-of-ocala/ for more information.

City of Ocala Health Center
2100 NE 30th Ave., Ocala, FL 34470
Monday, Thursday 7 a.m. - 5 p.m.
Tuesday, Wednesday 7 a.m. - 6 p.m.
Friday 8 a.m. - 5 p.m.
Closed daily 12 p.m.- 1 p.m.
Lab hours daily 8 a.m. - 10 a.m.
(352) 663-9156

Who can use these services?
For Medical: Services are available to all employees, dependents, spouses and retirees covered by the city's insurance plan. Occupational: All Employees.

Premise Health. Wellness Center | OCALA

COST SAVINGS TOOLS

Prescription Drug Cost Comparison Tools:

Use GoodRx and SingleCare's drug price search to compare prices (just like you do for travel or electronics on other sites) for your prescription at pharmacies near you. GoodRx as well as SingleCare do not sell the medications, the free website and mobile app will tell you where you can get the best deal on them. If you have insurance, your co-pay might not be the best price. Hundreds of generic medications are available for $4 or even free without insurance. Every week both GoodRx and SingleCare collect millions of prices and discounts from pharmacies, drug manufacturers and other sources. GoodRx and SingleCare will show you prices, coupons, discounts and savings tips for your prescriptions at pharmacies near you. There is no cost or membership required to use either of these cost savings tools. Please visit the websites at **www.goodrx.com and www.singlecare.com. You can also download these apps on your smartphone. Please note: amounts paid for prescriptions using GoodRx or SingleCare's discount programs do not apply toward your medical plan's deductible or annual out of pocket maximum.**

SingleCare

Pharmacy Discount Programs:

Before you pay for your next prescription, check to see if they are available for free or at a lower cost than traditional copays. Pharmacies such as Wal-Mart, Costco, CVS/Target, and Publix offer prescription discount programs that allow you to purchase medications for as low as $4 for a 30 day Supply (see each Pharmacy for specifics on their prescription discount program). If your local pharmacy is not listed below, please check with them to see if they offer any discounts.

Walmart Pharmacy

TARGET
CVS/pharmacy

Publix.

EAGLES, BENEFITS BY DESIGN FLEXIBLE SPENDING ACCOUNT (FSA)

You can pay for out-of-pocket medical, dental, vision, and/or dependent care expenses with pre-tax dollars through the Flexible Spending Account (FSA). **Important Note: If you will be funding an HSA, you cannot participate in the Health Care FSA.**

Maximum Annual Contributions	2024
Health Care Contribution Limit	$3,200
Dependent Care Contribution Limit	$5,000

Health Care FSA features:

- Plan year begins October 1st annually and ends September 30th
- Pre-tax contribution
- Pay for any qualified medical, dental, and vision expenses for yourself, spouse, or dependents. (See IRS Publication 502 for a complete list of qualified medical expenses- *sample list is below*.

Acupuncture	Blood Pressure monitor	Crutches/Wheelchair	Lasik/Vision Correction Surgery	Psychologist fees
Alcohol or Drug addiction treatment	Breast pump and supplies/accessories	Dental services	Long-Term Care	Smoking Cessation
Ambulance	Chiropractor Care	Diabetic monitors, test kits, strips & supplies	Medicines (prescriptions & over-the-counter)	Speech therapy
Bandages	Coinsurance & copayments	Fertility treatment	Oxygen	Sunscreen
Birth control	Contact lenses & glasses	Hearing aids & batteries	Psychiatric care	Vasectomy

A **Dependent Care FSA** is used to reimburse work related expenses; while you or your spouse work, look for work or attend school full-time or are physically unable to care for your dependent. Eligible children are under age 13, or a dependent who is physically or mentally not able to care for himself. Eligible expenses include nanny, nursery school, before care/after care, late pick-up fees, day camp, or day care. Your Dependent Care contribution is not pre-loaded to a debit card; you can only access what has been payroll deducted and is in your FSA.

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses incurred during the Plan Year. All eligible expenses must be incurred on or before September 30 in order to be eligible for reimbursement for that plan year. If you still have money in the account at the end of the plan year (September 30, 2024), you will have a 90-day run out period to submit for expenses that occurred during the previous plan year. The FSA debit card cannot be used for the runout period for prior year expenses.

When a transaction is marked as ineligible, it means that the FSA debit card was used to pay for something that is not FSA eligible per the IRS, or that receipts were never provided to show eligibility. It is the participants responsibility to provide documentation or reconcile the charges before the end of the runout period.

Health care FSA participants can rollover up to $640 from one plan year to the next. Dependent care FSA participants do not have a rollover option.

FLORIDA BLUE DENTAL INSURANCE

Network: Choice Plus
Website: www.floridabluedental.com

Benefits	Low PPO Plan	
	PPO Network	Non Network
Annual Deductible	$50/ $150 (Family)	$50/ $150 (Family)
Annual Plan Maximum	$1,000	$1,000
Orthodontia Lifetime Maximum	$1,000	$1,000
Diagnostics & Preventive Services		
Exams, Cleanings, X-Rays	100%	90%
Basic Services		
Fillings, Extractions, Root Canals	80%	60%
Major Services		
Crowns, Bridges, Dentures	50%	40%
Orthodontic Services		
Orthodontia Treatment	50%	50%

- Deductible does not apply to preventive services
- If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider's charges and the allowed amount.

	Monthly Cost for Coverage
Employee Only	$30.32
Employee + One	$47.00
Employee + Two or more	$74.20

For dental frequencies, please refer to certificate of coverage or benefit summary.

FLORIDA BLUE DENTAL INSURANCE

Network: Choice Plus
Website: www.floridabluedental.com

Benefits	High PPO Plan	
	PPO Network	Non Network
Annual Deductible	$50/ $150 (Family)	$50/ $150 (Family)
Annual Plan Maximum	$1,000	$1,000
Orthodontia Lifetime Maximum	$1,000	$1,000
Diagnostics & Preventive Services		
Exams, Cleanings, X-Rays	100%	100%
Basic Services		
Fillings, Extractions, Root Canals	80%	80%
Major Services		
Crowns, Bridges, Dentures	50%	50%
Orthodontic Services		
Orthodontia Treatment	50%	50%

- Deductible does not apply to preventive services
- If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider's charges and the allowed amount.

	Monthly Cost for Coverage
Employee Only	$41.48
Employee + One	$64.60
Employee + Two or more	$101.56

For dental frequencies, please refer to certificate of coverage or benefit summary.

STANDARD VISION INSURANCE

Network: EyeMed Select
Website: www.eyemedvisioncare.com

Benefits	Vision	
	PPO Network	Non-Network Reimbursements
Deductibles	$4 Exam/ $10 Lenses	No deductible
Eye Exams	Covered in Full	Up to $30
Eyeglass Lenses and Frames		
Single Standard Lenses	Covered in Full	Up to $20
Bifocal Standard Lenses	Covered in Full	Up to $40
Trifocal Standard Lenses	Covered in Full	Up to $60
Lenticular Standard Lenses	20% discount	Not covered
Frames	Up to $100, 20% discount on remaining balance	Up to $45
Contact Lenses		
Standard Fit and Follow Up	Up to $40	Not covered
Elective Lenses	Up to $100, 15% discount on remaining balance	Up to $85
Medically Necessary Lenses	Covered in full	Up to $200
Frequency		
Eye Exam	12 months	
Lenses—Eyeglass or Contact	12 months	
Frames	12 months	

	Monthly Cost for Coverage
Employee Only	$5.20
Employee + One	$10.36
Employee + Two or more	$16.24

For limitations & exclusions, please refer to certificate of coverage or benefit summary.

MINNESOTA LIFE

BASIC LIFE/AD&D & VOLUNTARY LIFE INSURANCE

Life insurance protects your family or other beneficiaries in the event of your death. The death benefit helps replace the income you would have provided and can help meet important financial needs. It can help pay your mortgage, rent, run your household, send your children to college, pay off debts, etc. The City of Ocala provides eligible, full-time employees a Life and AD&D benefit at no cost to the employee. Employees can also enroll in voluntary Life and AD&D insurance at a group rate for themselves, spouses, and children up to the age of 26.

Summary: Voluntary Life insurance

Employee Coverage (rate based on employee age)

Guarantee Issue	$150,000
Maximum Benefit Amount	$500,000
Increments of	$10,000

*Not to exceed 5x annual salary

Spouse Coverage (rate based on employee age)

Spouse Guarantee Issue	$30,000
Maximum Benefit Amount	$250,000
Increments of	$5,000

* Not to exceed 100% of employee's total basic + supplemental coverage amounts.

Child(ren) Coverage

Birth to 26 years	$10,000

Dependent Life Package	$10,000 spouse and $10,000 children

How to calculate your Voluntary Life/AD&D costs per paycheck:

1. Indicate your elected benefit amount (EBA)
2. Divide EBA by $1,000
3. Enter age rate from cost table
4. Multiply Step 2 by Step 3
5. Multiply Step 4 by 12 then divide by number of pay-cycles (24 or 26) to calculate your cost per paycheck

Employee Age	Rate per 1,000
Under 25	$0.063
25 – 29	$0.075
30 – 34	$0.100
35 – 39	$0.113
40 – 44	$0.150
45 – 49	$0.263
50 – 54	$0.463
55 – 59	$0.763
60 – 64	$0.938
65 – 69	$1.638
70 – 74	$2.575
75+	$2.975
Child Life	$1.30
Dependent Pkg	$4.95 per unit

* One premium insures all eligible children

Important Reminders

- Group AD&D Insurance terminates when an employee reaches age 70.
- You must be actively at work on the effective date, or your coverage will be delayed until you return to active employment.
- Evidence of Insurability (EOI) is required for employees who want to increase coverage at Open Enrollment and for new hires electing over the Guarantee Issue.

For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.

Automatic access to Lifestyle Benefits

Your employer's group insurance programs help protect your financial wellness. And you and your family can rely on a suite of additional tools, support, guidance and services to help make life a little easier.

Legal, financial and grief resources
from LifeWorks by Morneau Shepell

Travel assistance
from RedpointWTP LLC

Legacy planning resources
from Securian Financial

Beneficiary financial coaching
from Pricewaterhouse-Coopers LLP

There is no additional fee or enrollment for these resources. Just access the services you need, whenever you need them. Lifestyle Benefits are automatically available to active U.S. employees insured with Securian Financial. Your spouse and insurance-eligible children can also use these resources, even if they're not covered under the insurance program.

Legal, financial and grief resources

Access professional services for a variety of needs - from legal matters and financial situations to coping with loss - through comprehensive web and mobile resources, as well as consultations.

- **Legal:** Includes resources such as will prep templates - and a free, 30-minute consultation per issue, by phone or in an attorney's office (additional services available at 25 percent discount).
- **Financial:** Includes telephone consults or 45-minute counseling session per issue on many topics - from budget analysis to tax planning. Includes online access to a financial fitness assessment.
- **Grief support:** Access master's-level consultants by phone for any stage of grief and referrals for loss support.

How to access:

LifeBenefits.com/Lfg
username: lfg
password: resources

1-877-849-6034

Travel assistance

24/7 online, pre-trip resources and support for emergency travel assistance and other services when traveling 50+ miles from home.

- **Pre-trip planning and trip support:** Get passport, visa, immunization and currency conversion info.
- **Medical evacuation services:** Pre-hospital/rental vehicle assistance, transport to nearest appropriate medical facility once hospitalized, mortal remains repatriation, return of dependent children/pets, family member visitation, and travel companion transport.
- **Security evacuation services:** Transfer to nearest safe area, ID theft support and assistance replacing lost/stolen luggage.

How to access:

LifeBenefits.com/travel

U.S./Canada:
1-855-516-5433

All other locations:
1-415-484-4677

Before traveling, call Redpoint to learn more and add this contact info into your phone..

Legacy planning resources

Access a variety of online information/resources, including end-of-life and funeral planning, final arrangements, important directives and survivor assistance. After a claim is started, these additional services are available to beneficiaries by phone.

- **Funeral concierge:** Allows for coverage verification and direct payment to a funeral home so services can be provided before insurance payment is made.
- **Express Assignment™:** Same-day funeral home assignment service reduces concern about paying funeral expenses by working with the funeral home or lending agency.

How to access:

securian.com/legacy

Beneficiary financial coaching

Independent, objective and free financial coaching program for beneficiaries includes:

- **Dedicated financial coaching:** Available monthly via phone for help with financial decisions during first 6 months after claim is paid. Includes coaching the following 6 months, as needed.
- **Access to PwC Envision™:** 12 months of mobile-enabled web application with budgeting, planning tools and content.
- **Financial fitness assessment:** Personalized wellness report outlines key action items to discuss with a financial coach.
- **Survivor guide workbooks:** Help make financial and legal decisions less overwhelming.

How to access:

Beneficiaries receiving $25,000 or more will be invited to take advantage of this program when the life insurance claim is paid. Telephone financial guidance provided to beneficiaries receiving $100,000+.

securian FINANCIAL® | INSURANCE INVESTMENTS RETIREMENT

securian.com

400 Robert Street North, St. Paul, MN 55101-2098

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METLIFE VOLUNTARY SHORT-TERM DISABILITY

If you become unable to perform your regular job duties for an extended time due to sickness or accidental injury, you can be covered by the short-term disability (STD) policy.

Your income replacement benefit would equal 60% of your basic weekly earnings. The maximum weekly benefit you can receive is $1,000. Benefits begin to accrue on the day after you have been unable to work for 14 days due to a covered sickness or accident and will continue to be paid for either 13 or 26 weeks, depending on the plan you choose. Your STD benefit will be reduced by any disability income you receive from other sources, such as Social Security, worker's compensation, and/or state disability plans.

The STD plan contains a pre-existing condition exclusion. The exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought care within the 6-month period prior to the effective date of coverage and the disability begins within 12 months of the effective date of coverage.

The Estimated Rate Calculation below will be based on your annual salary and your age. The final premium calculations will be done by MetLife.

Short-Term Disability Calculation – Cost Per Paycheck	
A. Enter your annual salary	
B. Divide your annual salary by 52	
C. Enter the weekly benefit percentage	60%
D. Multiply "B" times "C"	
E. Enter the maximum weekly benefit	$1,000
F. Enter the lesser of "D" or "E". This is your benefit amount	
G. Multiply "F" times your monthly rate per $10 of benefit	
H. Divide "G" by $10	
I. Multiply "H" by 12	
J. Enter the annual pay cycle	
K. Divide "I" by "J". This is your premium (cost per paycheck)	

Short-Term Disability Calculation – Example 43-year-old, 13 weeks, $60,000 annual salary	
A. Enter your annual salary	$60,000
B. Divide your annual salary by 52	$1,153.85
C. Enter the weekly benefit percentage	60%
D. Multiply "B" times "C"	$692.31
E. Enter the maximum weekly benefit	$1,000
F. Enter the lesser of "D" or "E". This is your benefit amount	$692.31
G. Multiply "F" times your monthly rate per $10 of benefit	$283.85
H. Divide "G" by $10	$28.38
I. Multiply "H" by 12	$340.62
J. Enter the annual pay cycle	24
K. Divide "I" by "J". This is your premium (cost per paycheck)	$14.19

Employee Age	13 weeks Rate per $10	26 weeks Rate per $10
Under 25	$0.39	$0.54
25 but < 30	$0.41	$0.57
30 but < 35	$0.42	$0.58
35 but < 40	$0.38	$0.53
40 but < 45	$0.41	$0.57
45 but < 50	$0.49	$0.69
50 but < 55	$0.61	$0.86
55 but < 60	$0.75	$1.05
60 but < 65	$0.89	$1.25
65 or older	$1.07	$1.50

For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.

METLIFE VOLUNTARY LONG-TERM DISABILITY

If you become unable to perform your regular job duties for an extended time due to sickness or accidental injury, you can be covered by the long-term disability (LTD) policy.

Your income replacement benefit would equal 60% of your basic monthly earnings. The maximum monthly benefit you can receive is $10,000. Benefits begin after you have been unable to work for either 90 or 180 days (depending on the plan you elect) due to a covered sickness or accident and will continue to be paid to the later of your normal retirement age or as determined by the LTD age chart provided by MetLife.

Your LTD benefit will be reduced by any disability income you receive for other sources, such as Social Security, worker's compensation, and/or state disability plans.

The LTD plan contains a pre-existing condition exclusion. The exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought care within the 6-month period prior to the effective date of coverage and the disability begins within 12 months of the effective date of coverage.

The Estimated Rate Calculation below will be based on your monthly gross income and your age. The final premium calculations will be done by MetLife.

All Full-Time Employees Excluding Police and Fire Personnel

Employee Age	90-day Rate per $100	180-day Rate per $100
Under 35	$0.242	$0.176
35 but < 40	$0.416	$0.338
40 but < 45	$0.533	$0.435
45 but < 50	$0.794	$0.649
50 but < 55	$1.143	$0.950
55 but < 60	$1.650	$1.408
60 but < 65	$1.203	$0.889
65 or older	$0.454	$0.175

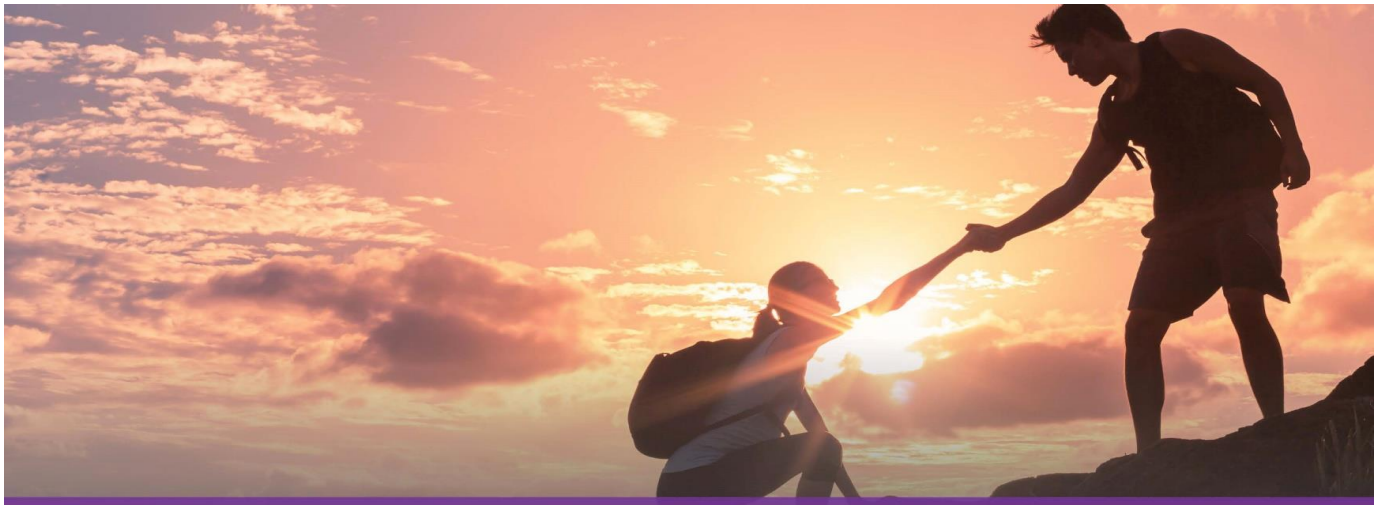
All Full-Time Police and Fire Personnel

Employee Age	90-day Rate per $100	180-day Rate per $100
Under 35	$0.182	$0.122
35 but < 40	$0.327	$0.264
40 but < 45	$0.510	$0.415
45 but < 50	$0.781	$0.645
50 but < 55	$1.028	$0.859
55 but < 60	$1.348	$1.114
60 but < 65	$1.140	$0.807
65 or older	$0.444	$0.239

Long-Term Disability Calculation – Example 43-year-old, Police and Fire, 90-day, $60,000 annual salary	
annual salary divided by 12 = monthly salary **($60,000/12)**	**$5,000**
Enter lesser of monthly salary or max monthly salary **max monthly salary = ($10,000/.60) = $6,000**	**$5,000**
Monthly salary times rate (see age banded table) divided by 100 = monthly premium **($5,000 x $0.533) = $2,665, $2,665/100=$26.65**	**$26.65**
(Monthly premium times 12) divided by 26 for bi-weekly or 24 for semi-monthly cost = cost per pay period **$26.65 x 12=$319.80/24=$0**	**$13.33**

For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.

AETNA EMPLOYEE ASSISTANCE PROGRAM (EAP)



Anytime support

Employee Assistance Program
To access services:
1-888-238-6232, TTY: 711
resourcesforliving.com
Username: ocalafl
Password: eap

City of Ocala

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. Children living away from home are covered up to age 26.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional wellbeing support

You can access up to 6 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face to face, online with televideo or by phone. Services are free and confidential. We're always here to help with a wide range of issues including:

- Anxiety
- Relationship support
- Depression
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Self-esteem and personal development
- Substance misuse and more

Daily life assistance

Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Care for older adults
- Caregiver support
- School and financial aid research
- Special needs
- Pet care
- Community resources/ basic needs
- Home repair and improvement
- Summer programs for kids
- Household services and more

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Resources *for* Living®

Legal services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Civil/Criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.

*Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Online resources

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars
- Mobile app

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

myStrength

myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse and/or chronic pain.

Financial services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions

You can get a 25 percent discount on tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.

*Services must be for financial matters related to the employee and eligible household members.

Additional services

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

MindCheck — Online tools that make it easy to improve your emotional wellbeing. Measure your mindset and get feedback and resources to maintain a positive outlook.

The EAP is administered by Resources For Living, LLC.

All EAP calls are confidential, except as required by law. Discount services are provided and managed by Lifecare, an independent third party. Resources For Living does not oversee or control the services provided by or recommended by Lifecare and does not assume any liability for their services. EAP instructors, educators and participating providers are independent contractors and are not agents of Resources For Living. Provider participation may change without notice.

Resources *for* Living®

LEGAL SHIELD LEGAL INSURANCE

LegalShield | IDShield

Affordable Legal and Identity Theft Protection

LegalShield and IDShield provide the legal and identity theft protection you and your family need and deserve.

AFFORDABLE LEGAL AND IDENTITY THEFT PROTECTION

LEGALSHIELD

FAMILY PLAN
$15.74
PER MONTH

IDSHIELD

EMPLOYEE PLAN	FAMILY PLAN
$6.94 PER MONTH	$12.94 PER MONTH

LEGALSHIELD & IDSHIELD

EMPLOYEE PLAN	FAMILY PLAN
$21.70 PER MONTH	$26.80 PER MONTH

Reduced rate pricing applies when enrolled in both plans.

FOR MORE INFORMATION, VISIT

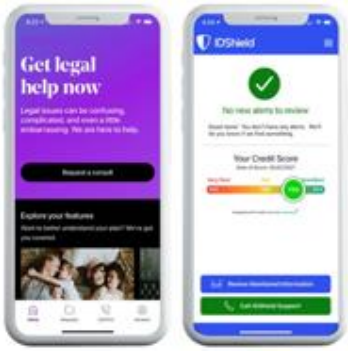
wwwshieldbenefits.com/ocala

LegalShield Coverage Includes:

- Legal Consultation and Advice
- Court Representation
- Dedicated Provider Law Firm
- Legal Document Preparation and Review
- Will Preparation
- Letters and Phone Calls Made on Your Behalf
- Speeding Ticket Assistance
- 24/7 Emergency Legal Access

IDShield Coverage Includes:

- Identity Consultation and Advice
- Dedicated Licensed Private Investigators
- Identity, Credit and Financial Account Monitoring
- Child Monitoring (Family Plan Only)
- Full-Service Identity Restoration
- Real-Time Alerts
- 24/7 Emergency Access
- Social Media Monitoring and Online Privacy Reputation Management



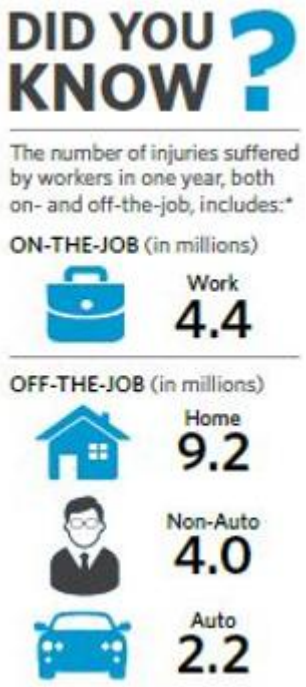
On-the-go protection!

With the LegalShield and IDShield mobile apps, you have on-the-go access, 24/7!

Download on the App Store
GET IT ON Google Play

ALLSTATE ACCIDENT INSURANCE

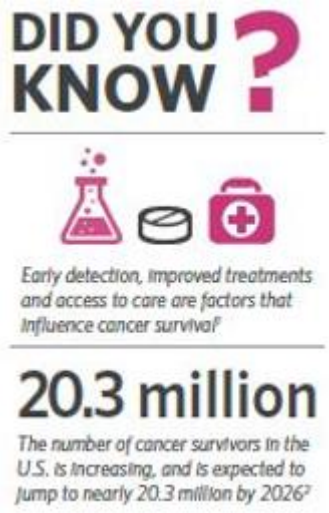
Accident Insurance arranged through Allstate offers protection for accidental injuries on-and-off the job, 24 hours a day. This coverage help pick up where other insurance leaves off and provides a cash benefit, directly to you, to cover the associated expenses due to an accidental injury. Coverage is guaranteed, meaning no medical questionnaire to complete, and is available to you and your dependents. Both a base (plan 1) and buy-up (plan2) plan are available.



PLAN 1 PREMIUMS				
Mode	EE only	EE+SP	EE+CH	Family
Semi-Monthly	$7.26	$13.44	$12.30	$18.48
PLAN 2 PREMIUMS				
Mode	EE only	EE+SP	EE+CH	Family
Semi-Monthly	$10.35	$19.62	$17.91	$27.18

ALLSTATE CANCER INSURANCE

Cancer Insurance offered through Allstate and pays a cash benefit to help with the costs associated with treatments, daily living expenses, and to empower you to seek the care you need. The coverage is guaranteed issue, meaning that no medical questionnaire is required for initial enrollment and the benefits are paid directly to you. The plan includes coverage for cancer as well as 29 specified diseases. Coverage is available for dependents and can be continued if you leave employment. For employees only, a waiver of premium is available after 90 days of disability due to cancer as long as your disability lasts. Both a base (plan 1) and buy-up (plan2) plan are available.



PLAN 1 PREMIUMS		
Mode	EE only	Family
Semi-Monthly	$8.62	$14.76
PLAN 2 PREMIUMS		
Mode	EE only	Family
Semi-Monthly	$14.06	$23.74

ALLSTATE CRITICAL ILLNESS

Critical Illness Insurance arranged through Allstate helps prepare you for a life-altering critical illness diagnosis. The treatment required for recovery is vital be can be very expensive. Medical coverage may only cover some of the associated costs leaving you with the cost for the deductible and coinsurance. Critical Illness coverage provides financial support by paying a cash benefit based on the percentage payable for a covered critical illness. Coverage is guarantee issue, meaning no medical questionnaire needs to be completed at initial enrollment. Coverage is available for dependents who are eligible for 50% of your basic benefit amount. Benefits are paid regardless of any other medical or disability coverage and can be taken with you if you leave employment. Both a base (plan 1) and buy-up (plan2) plan are available.

PLAN 1 SEMI-MONTHLY PREMIUM - Non-Tobacco				
Age	EE only	EE+SP	EE+CH	Family
18-35	$1.61	$2.50	$1.66	$2.60
36-49	$3.01	$4.65	$3.06	$4.70
50-59	$5.71	$8.60	$5.76	$8.70
60-64	$8.81	$13.25	$8.86	$13.30
65-69	$11.21	$16.80	$11.26	$16.90
70+	$13.46	$20.00	$13.51	$20.10
PLAN 1 SEMI-MONTHLY PREMIUM - Tobacco				
Age	EE only	EE+SP	EE+CH	Family
18-35	$2.16	$3.40	$2.21	$3.50
36-49	$4.91	$7.45	$4.91	$7.45
50-59	$10.31	$15.45	$10.41	$15.50
60-64	$14.56	$21.75	$14.61	$21.75
65-69	$16.86	$25.15	$16.96	$25.20
70+	$19.01	$28.30	$19.06	$28.40

PLAN 2 SEMI-MONTHLY PREMIUM - Non-Tobacco				
Age	EE only	EE+SP	EE+CH	Family
18-35	$2.54	$3.90	$2.64	$4.10
36-49	$5.34	$8.20	$5.44	$8.30
50-59	$10.74	$16.10	$10.84	$16.30
60-64	$16.94	$25.40	$17.04	$25.50
65-69	$21.74	$32.50	$21.84	$32.70
70+	$26.24	$38.90	$26.34	$39.10
PLAN 2 SEMI-MONTHLY PREMIUM – Tobacco				
Age	EE only	EE+SP	EE+CH	Family
18-35	$3.64	$5.70	$3.74	$5.90
36-49	$9.14	$13.80	$9.14	$13.80
50-59	$19.94	$29.80	$20.14	$29.90
60-64	$28.44	$42.40	$28.54	$42.40
65-69	$33.04	$49.20	$33.24	$49.30
70+	$37.34	$55.50	$37.44	$55.70

NATIONWIDE PET INSURANCE

Fetch the best health coverage for your pet through your voluntary benefits package. With two budget-friendly options, there's never been a better time to sign up for My Pet Protection®, available only through your workplace benefits program.

- **Get cash back on eligible vet bills:** Choose 50% or 70% reimbursement[1]
- **Easy to use:** Low $250 annual deductible and $7,500 in annual benefits
- **Just for employees:** Preferred pricing offered only through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Did you know? Nationwide is the first provider with coverage plans for birds and exotic pets.

How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed for eligible expenses.

http://www.petinsurance.com/ocalafl / 877-738-7874

[1] Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states.

Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH. Agency of Record: DVM Insurance Agency. All are subsidiaries of Nationwide Mutual Insurance Company. Subject to underwriting guidelines, review and approval. Products and discounts not available to all persons in all states. Insurance terms, definitions and explanations are intended for informational purposes only and do not in any way replace or modify the definitions and information contained in individual insurance contracts, policies or declaration pages, which are controlling. Nationwide, the Nationwide N and Eagle, and Nationwide is on your side are service marks of Nationwide Mutual Insurance Company. ©2023 Nationwide. 22GRP9056A

Nationwide®

Nationwide®

PetRx*Express*℠

Save time and money when filling pet prescriptions at a Walmart or Sam's Club pharmacy with Nationwide® **PetRx***Express*℠.

For no extra cost, our pet insurance members get discounts on Walmart's already low prices while enjoying the effortless convenience of automatic claim submission.

How it works

Using Nationwide® **PetRx***Express*℠ is easy and convenient for Nationwide pet insurance members.

1. Download a digital pet insurance card at **my.petinsurance.com**.
2. Take a prescription to any in-store Walmart or Sam's Club pharmacy, or have the veterinarian call it in.
3. Show the pet insurance card at the checkout and pay for the prescription.

That's it! The pharmacy will automatically submit a claim to Nationwide for processing, and you will be reimbursed for eligible expenses.*

*Reimbursement or co-insurance is based on coverage detailed in policy. See Nationwide **PetRx***Express*℠ Terms of Service. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions.

Get prescription pet meds for less

- Optional program available to all active Nationwide pet insurance members
- Receive discounted pricing on medications not covered by pet insurance
- No cost to use

http://www.petinsurance.com/ocalafl / 877-738-7874

Nationwide®

IMPORTANT NOTICES

Newborns' and Mothers' Health Protection Act

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

Notice of Special Enrollment Rights

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

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

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

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

To request special enrollment or obtain more information, please contact the plan administrator (see cover page for contact information).

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact HR at (352-629-8359).

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long-Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http://www.dol.gov/vets
An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier. For additional information, contact HR at (352-629-8359).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact HR at (352-629-8359).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member, or an embryo lawfully held by a member receive assistive reproductive services.

Notice Regarding Wellness Programs

The City of Ocala Wellness Program is a voluntary wellness program available to employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to enroll yourself or your spouse in a “with wellness” health insurance plan, you will be asked to complete a Health Risk Assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You and your spouse if applicable, will also be asked to complete a biometric screening, which will include a health questionnaire, 28-panel blood draw, and vital sign screening to measure your cholesterol levels, nutrition, liver function, chemistry levels and more. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees and spouses who choose to participate in the wellness program will receive a reduction in medical premium as an incentive for completing the HRA. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive a premium reduction.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and identify potential risk of diabetes, hypertension and other health concerns that could become more serious if not detected early. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and may use aggregate information it collects to design a program based on identified health risks in the workplace, City of Ocala Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are you, your attending physician and Florida Blue in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact HR at 352-629-8359.

IMPORTANT NOTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

IMPORTANT NOTICES

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

IMPORTANT NOTICES

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: October 1, 2024

IMPORTANT NOTICES

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Ocala 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:

- 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.
- City of Ocala has determined that the prescription drug coverage offered by FL Blue is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also 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 Ocala coverage will be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits. City of Ocala administers the group health coverage available to City of Ocala employees, retirees and dependents. The included prescription drug benefit provides:

	Network	Non-Network	Mail Order
Tier 1	$10 / $20	50% coinsurance	$20 / $40
Tier 2	$30 / $40	50% coinsurance	$60 / $80
Tier 3	$45 / $60	50% coinsurance	$90 / $120

If you do decide to join a Medicare drug plan and drop your current City of Ocala coverage, be aware that you and your dependents will not be able to get this coverage back.

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 City of Ocala 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 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through changes. You also may request a copy of this notice at any time.

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 drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). **Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Date: 10/01/2024
Name of Entity/Sender: City of Ocala
Contact- Position/Office: Ciara Torres HR
Address: 110 SE Watula Ave, Ocala, FL 34471
Phone number: 352-401-3988

IMPORTANT NOTICES

New Health Insurance Marketplace Coverage Options & Your Health Coverage

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

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name **City of Ocala**	**4. Employer Identification Number (EIN)** **59-6000392**	
5. Employer Address **110 SE Watula Ave**	**6. Employer Phone Number** **352-401-3988**	
7. City **Ocala**	**8. State** **Florida**	**9. ZIP Code** **34471**
10. Who can we contact about employee health coverage at this job? **Ciara Torres**		
11. Phone Number **352-401-3988**	**12. Email Address** **Ctorres@ocalafl.gov**	

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

IMPORTANT NOTICES

New Health Insurance Marketplace Coverage Options & Your Health Coverage

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

As your employer, we offer a health plan to:

☐ All employees.

☒ Some employees. Eligible employees are working 30 or more hours per week.

With respect to dependents:

☒ We do offer coverage. Eligible dependents are a spouse of the employee, a natural child, a stepchild, a legally adopted child, a child for whom legal guardian ship has been awarded to the employee or spouse, the newborn child of an enrolled dependent until the newborn reaches 18 months of age.

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums. The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

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

☒**Yes** (Continue)

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

☐ **No** (STOP and return this form to employee)

14.Does the employer offer a health plan that meets the minimum value standard*?

☒**Yes** (Go to question 15)☐**No** (Stop and return this form to employee)

15.For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan per month? $11.04

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

16.What change will the employer make for the new plan year?

☐Employer won't offer health coverage

☐Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

A.How much will the employee have to pay in premiums per month for that plan? $_____

Date of Change: _____

IMPORTANT NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program CHIP)

If you or your children are eligible for Medicaid or CHIP and you'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.

If 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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA 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

To see if any other states have added a premium assistance program since January 31, 2024, 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

WHO TO CALL

Benefit	Carrier	Phone #	Website
Broker	Brown & Brown	Morgan Legath 386-239-4067 Melanie Stegall 386-239-5779	bbrown.com
Medical Insurance	FL Blue	800-352-2583	floridablue.com
Employee Clinic	Premise Health	352-663-9156	mypremisehealth.com
Telephonic Health	Teledoc	800-835-2362	teledoc.com
Flexible Spending Account (FSA)	Eagles Benefits by Design	800-726-5603	eaglesbenefits.com
Employee Assistance Program (EAP)	Aetna	888-238-6232, TTY:711 Username: ocalafl Password: eap	resourcesforliving.com
Dental Insurance	Florida Combined Life	888-223-4892	floridabluedental.com
Vision Insurance	Standard	800-547-9515	standard.com/vision
Life/AD&D Insurance	Minnesota Life	800-392-7295	ochsinc.com
Short- and Long-Term Disability	MetLife	800-300-4296	metlife.com
Legal Insurance	Legal Shield	800-654-7757	benefits.legalshield.com/ocala
Pet Insurance	Nationwide	877-738-7874	petinsurance.com/ocalafl
Pharmacy Plan	Elect Rx	844-353-2879	electrx.com
Worksite Products	Allstate	Tom Watson 352-369-9453 352-237-0425	Email: custombenserv@msn.com

Brown & Brown

www.bbrown.com