2021 OPEN ENROLLMENT VIRTUAL MEETINGS
MEDICAL, DENTAL, VISION, AFLAC SUPPLEMENTAL, AND VOLUNTARY LIFE INSURANCE

This year's open enrollment will be conducted via virtual online meetings using GoToMeetings. There are three simple ways to participate: 1) Click one of the links below based on the time you're interested in attending. You will be able to join by audio, or both audio and video, or 2) Copy and paste the chosen meeting link below into your web browser, or 3) Go to www.gotomeeting.com and join a meeting by entering the 9-digit meeting number (no dashes) found at the end of each link below. Not into technology, no problem….simply call Karin Graves, Employee Benefits Specialists at (954) 838-4528 or email kgraves@sunrisefl.gov for immediate assistance.

Open enrollment is the time of year when you are able to make changes to your employee group insurance benefits. These changes may be adding or deleting eligible dependents, discontinuing coverage, changing between plans, updating beneficiary forms, or electing new coverage for the first time. The effective date for coverage changes is January 1, 2021. There are no changes in rates or benefit levels this upcoming year for medical, dental, vision and voluntary life insurance. AFLAC supplemental coverages will remain the same for existing participants, but offer new plans and rates for newly elected coverage. Unless you are electing new coverage for the first time, or making changes to your existing coverage, your current benefits will continue uninterrupted and there is nothing you need to do.

1-HOUR VIRTUAL MEETINGS HELD DURING THE FOLLOWING TIMES:

Monday, October 19th at 10:00am
https://global.gotomeeting.com/join/505695877
Tuesday, October 20th at 9:00am
https://global.gotomeeting.comj/oin/383536453
Wednesday, October 21st at 8:00am
https://global.gotomeeting.com/join/216569045
Thursday, October 22nd at 3:00pm
https://global.gotomeeting.com/join/432721781
Friday, October 23rd at 10:00am
https://global.gotomeeting.com/join/987111629
Monday, October 26th at 1:00pm
https://global.gotomeeting.com/join/135798405
Tuesday, October 27th at 7:00am
https://global.gotomeeting.com/join/116529245
Wednesday, October 28th at 10:00am
https://global.gotomeeting.com/join/487119141
Thursday, October 29th at 8:00am
https://global.gotomeeting.com/join/648707893
Friday, October 30th at 10:00am
https://global.gotomeeting.com/join/911664685

Monday, October 19th at 2:00pm
https://global.gotomeeting.com/join/637054117
Tuesday, October 20th at 12:00pm
https://global.gotomeeting.com/join/411375533
Wednesday, October 21st at 1:00pm
https://global.gotomeeting.com/join/755984181
Thursday, October 22nd at 8:00pm
https://global.gotomeeting.com/join/151490949
Friday, October 23rd at 4:00pm
https://global.gotomeeting.com/join/390069397
Monday, October 26th at 6:00pm
https://global.gotomeeting.com/join/612096669
Tuesday, October 27th at 7:00pm
https://global.gotomeeting.com/join/406638965
Wednesday, October 28th at 7:00pm
https://global.gotomeeting.com/join/641275029
Thursday, October 29th at 12:00pm
https://global.gotomeeting.com/join/532204693
Friday, October 30th at 2:00pm
https://global.gotomeeting.com/join/948066821

Sessions are open to all eligible employees, dependents and retirees. Open Enrollment information is available on both CityConnect (City's intranet) under Risk Management/Benefits, and on the City's website (www.sunrisefl.gov) under Departments/Finance & Administrative Services/Risk Management. Enrollment forms will be accepted either via e-mail, interoffice mail, or regular mail to City of Sunrise, Risk Management Division, 10770 W. Oakland Park Blvd., 3rd Floor, Sunrise, FL 33351.

The deadline to submit your enrollment forms to Risk Management is November 13, 2020, by 5:00PM.

City of Sunrise Health, Dental and Vision Plan Payroll Deductions
All Non-Management Employees (regardless of hire/promotion date)
and Management Employees Hired/Promoted after 05/01/2009 Rates
Effective January 1, 2021

HEALTH - AvMed	Employee Biweekly Deduction	
	Employee Only	Employee + 1 or More Dependents
HMO	0.00	175.01
POS	92.66	413.49

DENTAL - MetLife/Safeguard	Employee Biweekly Deduction		
	Employee Only	Employee +1 Dependent	Employee + 2 or More Dependents
HMO	7.79	13.65	21.44
PPO-Low Option ($1,000)	13.74	26.03	40.76
PPO-High Option ($2,000)	21.51	40.74	63.79

	Employee Biweekly Deduction	
Vision	Employee Only	Employee + 1 or More Dependents
Humana	3.05	7.40

City of Sunrise Florida __New Enrollment __Reinstate
Employee Group Medical, Dental and Vision Plan __Open Enrollment __Change

OFFICE USE ONLY
Effective Date of Coverage:_____/_____/_____ Classification:_____

Subscriber Information

Employee Last Name	First Name	M.I.	Social Security Number*	Date of Birth	Gender __M __F

Mailing Address	Apt.	City	State	Zip	Phone ( ) _____- _____

Department/Division	Job Title	Date of Hire		Work Phone (if any) ( ) _____ - _____

If this is a Change, Indicate Type: __Add Dependent(s) __Drop Dependent(s) __Drop Employee and Dependent(s), if any
(attach document for proof) **Changes must be made within 31 days of qualifying event, as per IRS Sec 125 guidelines**

__New address(as above), __New Name: From_____ to _____

This Change is due to: ___Marriage ___Birth ___Separation of Employment ___Other:_____ Date of Event: _____

Additional Information

Other than this Health Plan, will you and/or your family have other Health Insurance Coverage as of this date? __Yes __No Dental? __Yes __No

If yes, list Covered Person(s):_____

Insurance Company Name: _____ Do you or your spouse have Medicare? __Yes __No

Covered Individuals	**Medical-HMO**	**Medical-POS**	**Dental-HMO**	**Dental-HMO**	**Dental-PPO Low Option**	**Dental-PPO High Option**	**Vision**
Indicate your medical, dental and/or vision coverage options by placing an X in the appropriate ( )	**Indicate Option**	**Indicate Option**	**Indicate Option**	**Employee Facility #**	**Indicate Option**	**Indicate Option**	**Indicate Option**
Single	( )	( )	( )		( )	( )	( )
Employee and One Dependent*	**N/A**	**N/A**	( )	**N/A**	( )	( )	**N/A**
Family	( )	( )	( )	**N/A**	( )	( )	( )

*Eligible dependents are: spouse and/or natural, adopted or awarded child as defined in the plan document.

List below **all** eligible dependents you wish to cover on your medica,dental or vision plan. This enrollment form will replace all previously completed forms. Only those listed below will have coverage on the effective date of this enrollment or change.

Last Name First M.I.	**Date of Birth**	**Gender**	**Social Security Number***	**Coverage Selection**
(2)Spouse	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(3) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(4) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(5) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____
(6) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___Add Dental ___Drop Dental ___Add Vision ___Drop Vision DHMO Facility # _____

Proper documents required: marriage certificate, birth certificate, hospital birth record, adoption award, medical child support order.

Authorization

I hereby (1) **REQUEST** coverage for the Group Medical, Dental and/or Vision Plan for which I am, or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the Health Plan. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to any illness, injury, or medical history to the claims payor, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made directly to the hospital or physician for services rendered unless paid receipts are presented. *Your social security number is requested for the purpose of payroll eligibility verification, processing employment benefits, applicant and employee background checks, and income reporting. In addition, the social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Employee Signature _____ **Date**_____

Declination

I hereby **DECLINE** ___Medical ___Dental and/or ___Vision coverage at this time. I realize that I cannot elect coverage until the next enrollment period unless I have a qualifying event as allowed in the Plan Document.

Employee Signature _____ **Date**_____

MEDICAL INSURANCE

ONLY THIS YEAR'S FLU SHOT
will protect you from this year's flu

Flu viruses constantly change from one year to the next. So the annual vaccine changes as well.

And if you count on last year's flu shot – or take a "wait and see" approach, it could be too late to get the protection you need.

For more than 50 years, hundreds of millions of flu vaccines – including millions more H1N1 vaccines – have maintained a strong safety record, closely monitored by the Food and Drug Administration and the Centers for Disease Control and Prevention. The CDC recommends that everyone 6 months of age and older get the Flu Vaccine.

One reason the flu is so serious is because of its complications, including pneumonia, ear infections and sinus infections. It also can be especially concerning for babies under two years old, pregnant women, older adults and those with chronic conditions, such as asthma or diabetes.

That's why it's important to get an updated flu shot – earlier rather than later – every single year. That goes for the people you care about, too.

MORE THAN 50 YEARS OF PROVEN SAFETY

It's Easy To Get Your Free Flu Shot. Just go to:

- Your Physician's Office
- Participating Pharmacies and be sure to show your AvMed ID Card

Don't depend on last year's vaccine to protect you from this year's flu. It's the best and safest protection possible for you and the people you care about.

Get vaccinated today.

AvMed

Embrace better health.®

MP-7009 (09/20) En español al reverso

AvMed **City of Sunrise Large Group HMO**

Coverage for: Individual or Individual + Family| **Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-263-2369 or visit www.avmed.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-844-263-2369 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** individual/ **$0** family	See the Common Medical Event chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	This plan has no deductible in the AvMed Network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,000** individual/ **$4,000** family. Includes copays and coinsurance cost-sharing.	The out-of-pocket limit is the most you could pay covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.avmed.org or call 1-844-263-2369** for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

(DT - OMB control number: 1545-0047/Expiration DATE: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration DATE: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration DATE: 10/31/2022)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Our of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/ visit $20 copay/ visit for podiatry services No charge for virtual visits	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Specialist visit	$35 copay/ visit	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Charges for office visits may apply if services are performed in a Physician's office.
	Imaging (CT/PET scans, MRIs)	$50 copay/ visit at independent facility; $100 copay/ visit at hospital affiliated facilities	Not Covered	Charges for office visits or Physician/professional services may also apply depending where services are received. Certain services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.avmed.org	Generic drugs (Tier 1)	$10 copay/ prescription (retail); $20 copay/ prescription (mail order)	Not Covered	Retail charge applies per 30-day supply. Generic & brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order. Certain drugs in all tiers require prior authorization. Brand additional charges may apply. Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order.
	Preferred brand drugs (Tier 2)	$50 copay/ prescription (retail); $100 copay/ prescription (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	$75 copay/ prescription (retail); $150 copay/ prescription (mail order)	Not Covered	
	Specialty drugs (Tier 4)	25% coinsurance (retail only)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Our of Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/ visit	Not Covered	Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	$200 copay/ visit	$200 copay/ visit	AvMed must be notified within 24-hours of impatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted.
	Emergency medical transportation	No Charge	No Charge	----------None----------
	Urgent care	$30 copay/ visit at urgent care facilities; $30 copay/ visit at retail clinics	$60 copay/ visit at urgent care facilities or retail clinics	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/ day for the first 3 days per admission	Not Covered	Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/ visit	Not Covered	----------None----------
	Inpatient services	Hospital stay: $100 copay/ day for the first 3 days per admission Residential stay: No Charge	Not Covered	Prior authorization required. Residential stay is limited to 100 days per calendar year.
If you are pregnant	Office visits	Routine OB & Midwife services: $15 copay/ visit	Not Covered	----------None----------
	Childbirth/delivery professional services	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: $100 copay/ day for the first 3 days per admission Birthing center: Same as Routine OB	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Our of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$15 copay/ visit	Not Covered	Limited to 60 skilled visits per calendar year. Approved treatment plan required.
	Rehabilitation services	$10 copay/ visit; $15 copay/ visit for chiropractic services	Not Covered	Limited to 60 visits per calendar year for rehabilitative physical, occupational and speech therapies combined; 18 visits per calendar year for cardiac rehabilitation. Cardiac rehabilitation requires prior authorization. Spinal manipulation is limited to 60 visits per calendar year.
	Habilitation services	No Charge	Not Covered	Limited to 100 visits per calendar year for habilitative physical, occupational, & speech therapies combined, when provided for the treatment of autism spectrum disorder and Down syndrome.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	No charge for DME supplied on an outpatient basis	Not Covered	Some limitations apply. Please see your Summary Plan Description for details.
	Hospice services	No Charge	Not Covered	Physician certification required.
If your child needs dental or eye care	Children's eye exam	$15 copay/ visit	Not Covered	Eye exam to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Children's dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Florida Office of Insurance Regulation at 1-877-693-5236 or www.floir.com/consumers, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa/contactEBSA/consumerassistance.html, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact AvMed's Member Engagement Center at 1-800-682-8633. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Florida Department of Financial Services, Division of Consumer Services, at 1-877-693-5236 or www.floir.com/consumers.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 1-844-263-2369.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$100
Other payment	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$260

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$100
Other payment	$0

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,320

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$100
Other copayment	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,300

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Mia would pay is	$500

The plan would be responsible for the other costs of these EXAMPLE covered services.

AvMed **City of Sunrise Large Group POS**

Coverage for: Individual or Individual + Family| **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-263-2369 or visit www.avmed.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-844-263-2369 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	AvMed Network: **$500** individual/ **$1,000** family Out-of-Network: **$1,000** individual/ **$2,000** family	Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. Office visits, preventive care, diagnostic test, imaging, and prescription drugs are covered before you meet your deductible.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	AvMed Network: **$2,000** individual/ **$4,000** family Out-of-Network: **$4,000** individual/ **$8,000** family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Premiums, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.avmed.org or call 1-844-263-2369** for a list of participating providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays **(balance billing)**. Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

(DT - OMB control number: 1545-0047/Expiration DATE: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration DATE: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration DATE: 10/31/2022)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/ visit $30 copay/ visit for podiatry services No charge for virtual visits	40% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the Physician's office.
	Specialist visit	$60 copay/ visit	40% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the Physician's office.
	Preventive care/screening/ immunization	No Charge	40% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge at freestanding facilities; 20% coinsurance after deductible at outpatient hospital facilities	40% coinsurance after deductible	Charges for office visits may apply if services are performed in a Physician's office.
	Imaging (CT/PET scans, MRIs)	$50 copay/ test at freestanding facilities; $75 copay/ visit at hospital affiliated facilities	40% coinsurance after deductible	Charges for office visits or Physician/professional services may also apply depending where services are received. Certain services require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.avmed.org	Generic drugs (Tier 1)	$10 copay/ prescription (retail); $20 copay/ prescription (mail order)	Not Covered	Retail charge applies per 30-day supply. Generic & brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order. Certain drugs in all tiers require prior authorization. Brand additional charges may apply. Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order.
	Preferred brand drugs (Tier 2)	$50 copay/ prescription (retail); $100 copay/ prescription (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	$75 copay/ prescription (retail); $150 copay/ prescription (mail order)	Not Covered	
	Specialty drugs (Tier 4)	25% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required.
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	----------None----------
	Urgent care	$30 copay/ visit at urgent care facilities; $30 copay/ visit at retail clinics	40% coinsurance after deductible	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/ visit	40% coinsurance after deductible	----------None----------
	Inpatient services	Hospital stay: 20% coinsurance after deductible; Residential stay: 20% coinsurance after deductible;	40% coinsurance after deductible	Prior authorization required. Residential stay is limited to 100 days per calendar year.
If you are pregnant	Office visits	Routine OB & Midwife services: $15 copay/ visit	40% coinsurance after deductible	----------None----------
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: 20% coinsurance after deductible Birthing center: Same as Routine OB	40% coinsurance after deductible	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 60 skilled visits per calendar year. Approved treatment plan required.
	Rehabilitation services	20% coinsurance after deductible; $30 copay/ visit for chiropractic services	40% coinsurance after deductible	Limited to 60 visits per calendar year for rehabilitative physical, speech & occupational therapies combined; 18 visits per calendar year for cardiac rehabilitation. Cardiac rehabilitation requires prior authorization. Limited to 60 visits per calendar year for Spinal Manipulation.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 100 visits per calendar year for habilitative physical, occupational and speech services combined, when provided for the treatment of autism spectrum disorder and Down syndrome.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 100 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Some limitation apply. Please see your Summary Plan Description for details.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Physician certification required.
If your child needs dental or eye care	Children's eye exam	$10 copay/ visit	40% coinsurance after deductible	Eye exam to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Children's dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Florida Office of Insurance Regulation at 1-877-693-5236 or www.floir.com/consumers, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa/contactEBSA/consumerassistance.html, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact AvMed's Member Engagement Center at 1-800-682-8633. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Florida Department of Financial Services, Division of Consumer Services, at 1-877-693-5236 or www.floir.com/consumers.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 1-844-263-2369.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,420

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,200

The plan would be responsible for the other costs of these EXAMPLE covered services.

DENTAL INSURANCE

Dental

Metropolitan Life Insurance Company

Network: PDP Plus

	PLAN OPTION 1 Enhanced Plan		PLAN OPTION 2 PPO Plan	
Coverage Type	**In-Network** % of Negotiated Fee*	**Out-of-Network** % of R&C Fee**	**In-Network** % of Negotiated Fee*	**Out-of-Network** % of Negotiated Fee*
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%	50%	50%
Type D: Orthodontia	50%	50%	50%	50%
Deductible†				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Annual Maximum Benefit				
Per Person	$2,000	$2,000	$1,000	$1,000
Orthodontia Lifetime Maximum				
Per Person	$2,000	$2,000	$1,000	$1,000

Child(ren)'s eligibility for dental coverage is from birth up to age 26.
Late enrollment waiting period: There is a one year waiting period for Type C & Orthodontia services.

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. (Only applies to the Enhanced Plan)

†Applies only to Type B & C Services.

List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Plan Option 1: High Plan		**Plan Option 2:** Basic Plan	
Type A – Preventive	**How Many/How Often**	**Type A – Preventive**	**How Many/How Often**
Prophylaxis (cleanings)	▪ One every 6 months	Prophylaxis (cleanings)	▪ One every 6 months
Oral Examinations	▪ One every 6 months	Oral Examinations	▪ One every 6 months
Topical Fluoride Applications	▪ One fluoride treatment per 12 months for dependent children up to his/her 14th birthday	Topical Fluoride Applications	▪ One fluoride treatment per 12 months for dependent children up to his/her 14th birthday
X-rays	▪ Bitewings X-rays; one set per 12 months	X-rays	▪ Bitewings X-rays; one set per 12 months
Space Maintainers	▪ Space maintainers for dependent children up to his/her 14th birthday, Once per tooth area per lifetime	Space Maintainers	▪ Space maintainers for dependent children up to his/her 14th birthday, Once per tooth area per lifetime
Sealants	▪ One application of sealant material per lifetime for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 14th birthday	Sealants	▪ One application of sealant material per lifetime for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 14th birthday
Type B – Basic Restorative	**How Many/How Often**	**Type B – Basic Restorative**	**How Many/How Often**
X-rays	▪ Full mouth X-rays; one per 60 months	X-rays	▪ Full mouth X-rays; one per 60 months
Fillings	▪ Replacement once every 12 months	Fillings	▪ Replacement once every 12 months
Simple Extractions		Simple Extractions	
Periodontics	▪ Periodontal scaling and root planing once per quadrant, every 36 months ▪ Total number of periodontal maintenance treatments and prophylaxis cannot exceed one treatment in a 6 month period	Periodontics	N/A
Type C – Major Restorative	**How Many/How Often**	**Type C – Major Restorative**	**How Many/How Often**
Crown, Denture and Bridge Repair/ Recementations		Crown, Denture and Bridge Repair/ Recementations	
Oral Surgery (including Surgical extractions)		Oral Surgery (Including Surgical extractions)	
Implants	▪ Replacement once every 84 months	Implants	▪ Not covered
Bridges and Dentures	▪ Initial placement to replace one or more natural teeth, which are lost while covered by the plan ▪ Dentures and bridgework replacement; one every 84	Bridges and Dentures	▪ Initial placement to replace one or more natural teeth, which are lost while covered by the plan ▪ Dentures and bridgework replacement; one every 84

	months ▪ Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed		months ▪ Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	▪ Replacement once every 84 months, minimum age requirement of 16	Crowns, Inlays and Onlays	▪ Replacement once every 84 months, minimum age requirement of 16
Endodontics	▪ Root canal treatment limited to once per tooth per 24 months	Endodontics	▪ Root canal treatment limited to once per tooth per 24 months
General Anesthesia	▪ When dentally necessary in connection with oral surgery, extractions or other covered dental services	General Anesthesia	▪ When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	▪ Periodontal surgery once per quadrant, every 36 months	Periodontics	▪ Periodontal scaling and root planing once per quadrant, every 36 months ▪ Periodontal surgery once per quadrant, every 36 months ▪ Total number of periodontal maintenance treatments and prophylaxis cannot exceed one treatment in a 6 month period
Type D – Orthodontia	**How Many/How Often**	**Type D – Orthodontia**	**How Many/How Often**
	▪ Your children, up to age 26, are covered while Dental insurance is in effect. ▪ All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia ▪ Payments are on a repetitive basis ▪ 25% of the amount charged by the dentist will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary ▪ Orthodontic benefits end at cancellation of coverage		▪ Your children, up to age 26, are covered while Dental insurance is in effect. ▪ All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia ▪ Payments are on a repetitive basis ▪ 25% of the amount charged by the dentist will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary ▪ Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Frequently Asked Questions

Who is a participating dentist?
A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30%-45% below the average fees charged in a dentist's community for the same or substantially similar services.[†]

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1 800 GET-MET8 (1-800-438-6388) to have a list faxed or mailed to you.

What services are covered under this plan?
The certificate of insurance sets forth the covered services under the plan. Please review the enclosed plan benefits to learn more.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.[††] The website and phone number are for use by dental professionals only.

How are claims processed?
Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1 800 GET-MET8 (1-800-438-6388)

Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?
Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through international dental travel assistance services[*] you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.[**] Please remember to hold on to all receipts to submit a dental claim.

How does MetLife coordinate benefits with other insurance plans?
Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Do I need an ID card?
No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
††Due to contractual requirements, MetLife is prevented from soliciting certain providers.
* AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.
**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;

- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal (Basic Plan only)
- Repair of implants; (Basic Plan only)
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth; (High Plan only)
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-438-6388 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 90 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the certificate of insurance or contact MetLife.

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MetLife

SCHEDULE OF BENEFITS

Benefits provided by SafeGuard Health Plans, Inc., a MetLife company

Direct Referral Dental Plan SGCM1029

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations.

During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist. Your selected general dentist may refer you directly to a contracted SafeGuard specialty care provider; no referral or pre-authorization from SafeGuard is required.

Missed Appointments: If you need to cancel or reschedule an appointment, you should notify the dental office as far in advance as possible. This will allow the dental office to accommodate another person in need of attention.

Code	Service	Co-payment
	Diagnostic Treatment	
D0120	Periodic oral evaluation – established patient	$0
D0140	Limited oral evaluation – problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation – new or established patient	$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	$0
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	$0
D0171	Re-evaluation – post-operative office visit	$0
D0180	Comprehensive periodontal evaluation – new or established patient	$0
•	Office visit - per visit (including all fees for sterilization and/or infection control)	$5
	Radiographs/Diagnostic Imaging (X-rays)	
D0210	Intraoral – complete series of radiographic images	$0
D0220	Intraoral – periapical first radiographic image	$0
D0230	Intraoral – periapical each additional radiographic image	$0
D0240	Intraoral – occlusal radiographic image	$0
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing – single radiographic image	$0
D0272	Bitewings – two radiographic images	$0
D0273	Bitewings – three radiographic images	$0
D0274	Bitewings – four radiographic images	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	Panoramic radiographic image	$0

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
	Tests and Examinations	
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Laboratory accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0
	Preventive Services	
D1110	Prophylaxis – adult*	$0
•	Additional-adult prophylaxis (maximum of 2 additional per year)	$35
D1120	Prophylaxis – child*	$0
•	Additional-child prophylaxis (maximum of 2 additional per year)	$25
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride – excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant – per tooth	$0
D1510	Space maintainer – fixed – unilateral	$25
D1516	Space maintainer – fixed – bilateral, maxillary	$25
D1517	Space maintainer – fixed – bilateral, mandibular	$25
D1520	Space maintainer – removable – unilateral	$35
D1526	Space maintainer – removable – bilateral, maxillary	$35
D1527	Space maintainer – removable – bilateral, mandibular	$35
D1550	Re-cement or re-bond space maintainer	$15
D1555	Removal of fixed space maintainer	$15
	Restorative Treatment	
D2140	Amalgam – one surface, primary or permanent	$0
D2150	Amalgam – two surfaces, primary or permanent	$0
D2160	Amalgam – three surfaces, primary or permanent	$0
D2161	Amalgam – four or more surfaces, primary or permanent	$0
D2330	Resin-based composite – one surface, anterior	$0
D2331	Resin-based composite – two surfaces, anterior	$0
D2332	Resin-based composite – three surfaces, anterior	$0

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$0
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite – one surface, posterior	$30
D2392	Resin-based composite – two surfaces, posterior	$45
D2393	Resin-based composite – three surfaces, posterior	$65
D2394	Resin-based composite – four or more surfaces, posterior	$65
	Crowns	
	• *An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a $75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.*	
	• *Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.*	
D2510	Inlay – metallic – one surface	$225
D2520	Inlay – metallic – two surfaces	$235
D2530	Inlay – metallic – three or more surfaces	$245
D2542	Onlay – metallic – two surfaces	$245
D2543	Onlay – metallic – three surfaces	$260
D2544	Onlay – metallic – four or more surfaces	$270
D2610	Inlay – porcelain/ceramic – one surface	$245
D2620	Inlay – porcelain/ceramic – two surfaces	$245
D2630	Inlay – porcelain/ceramic – three or more surfaces	$245
D2642	Onlay – porcelain/ceramic – two surfaces	$245
D2643	Onlay – porcelain/ceramic – three surfaces	$245
D2644	Onlay – porcelain/ceramic – four or more surfaces	$245
D2650	Inlay – resin-based composite – one surface	$245
D2651	Inlay – resin-based composite – two surfaces	$245
D2652	Inlay – resin-based composite – three or more surfaces	$245
D2662	Onlay – resin-based composite – two surfaces	$245
D2663	Onlay – resin-based composite – three surfaces	$245
D2664	Onlay – resin-based composite – four or more surfaces	$245
D2710	Crown – resin-based composite (indirect)	$245
D2712	Crown – ¾ resin-based composite (indirect)	$245
D2720	Crown – resin with high noble metal	$245
D2721	Crown – resin with predominantly base metal	$245
D2722	Crown – resin with noble metal	$245
D2740	Crown - porcelain/ceramic	$245
D2750	Crown – porcelain fused to high noble metal	$245
D2751	Crown – porcelain fused to predominantly base metal	$245
D2752	Crown – porcelain fused to noble metal	$245
D2780	Crown – ¾ cast high noble metal	$245
D2781	Crown – ¾ cast predominantly base metal	$245
D2782	Crown – ¾ cast noble metal	$245
D2783	Crown – ¾ porcelain/ceramic	$245
D2790	Crown – full cast high noble metal	$245

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D2791	Crown – full cast predominantly base metal	$245
D2792	Crown – full cast noble metal	$245
D2794	Crown – titanium	$245
D2799	Provisional crown - further treatment or completion of diagnosis necessary prior to final impression	$0
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$0
D2930	Prefabricated stainless steel crown – primary tooth	$25
D2931	Prefabricated stainless steel crown – permanent tooth	$25
D2932	Prefabricated resin crown	$45
D2933	Prefabricated stainless steel crown with resin window	$45
D2940	Protective restoration	$0
D2950	Core buildup, including any pins when required	$70
D2951	Pin retention – per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$50
D2953	Each additional indirectly fabricated post – same tooth	$50
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal	$10
D2957	Each additional prefabricated post – same tooth	$30
D2960	Labial veneer (resin laminate) – chairside	$250
D2961	Labial veneer (resin laminate) – laboratory	$300
D2962	Labial veneer (porcelain laminate) – laboratory	$350
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2980	Crown repair necessitated by restorative material failure	$0
	Endodontics	
	All procedures exclude final restoration.	
D3110	Pulp cap – direct (excluding final restoration)	$5
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$25
D3221	Pulpal debridement, primary and permanent teeth	$55
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$40
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$40
D3310	Anterior (excluding final restoration)	$100
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$152
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$210
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$96
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy – anterior	$180
D3347	Retreatment of previous root canal therapy - premolar	$280
D3348	Retreatment of previous root canal therapy – molar	$325

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$70
D3352	Apexification/recalcification – interim medication replacement	$70
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3410	Apicoectomy – anterior	$55
D3421	Apicoectomy - premolar (first root)	$80
D3425	Apicoectomy – molar (first root)	$95
D3426	Apicoectomy (each additional root)	$45
D3430	Retrograde filling – per root	$30
D3450	Root amputation – per root	$70
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal), not including root canal therapy	$75
D3950	Canal preparation and fitting of preformed dowel or post	$15
	Periodontics	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	$100
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	$60
D4240	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4241	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$113
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening – hard tissue	$150
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	$300
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	$180
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$180
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration – resorbable barrier, per site	$215
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	$255
D4270	Pedicle soft tissue graft procedure	$245
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$75
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$100
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$380
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$75
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or	$380

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	edentulous tooth position in same graft site	
D4320	Provisional splinting – intracoronal	$50
D4321	Provisional splinting – extracoronal	$75
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$50
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$30
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$50
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$65
D4910	Periodontal maintenance (2 in a 12 month period)	$40
D4999	Unspecified periodontal procedure, by report Periodontal charting for planning treatment of periodontal disease	$0
•	Unspecified periodontal procedure, by report Periodontal hygiene instruction	$0
	Removable Prosthodontics	
•	*Includes up to 3 adjustments within 6 months of delivery.*	
D5110	Complete denture – maxillary	$325
D5120	Complete denture – mandibular	$325
D5130	Immediate denture – maxillary	$350
D5140	Immediate denture – mandibular	$350
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$400
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$400
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$425
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$425
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$400
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$400
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$425
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$425
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$425
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$425
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	$300
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	$300
D5410	Adjust complete denture – maxillary	$10
D5411	Adjust complete denture – mandibular	$10
D5421	Adjust partial denture – maxillary	$10
D5422	Adjust partial denture – mandibular	$10
D5511	Repair broken complete denture base, mandibular	$35
D5512	Repair broken complete denture base, maxillary	$35

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D5520	Replace missing or broken teeth – complete denture (each tooth)	$35
D5611	Repair resin partial denture base, mandibular	$35
D5612	Repair resin partial denture base, maxillary	$35
D5621	Repair cast partial framework, mandibular	$35
D5622	Repair cast partial framework, maxillary	$35
D5630	Repair or replace broken retentive clasping materials – per tooth	$35
D5640	Replace broken teeth – per tooth	$35
D5650	Add tooth to existing partial denture	$35
D5660	Add clasp to existing partial denture - per tooth	$35
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$75
D5711	Rebase complete mandibular denture	$75
D5720	Rebase maxillary partial denture	$75
D5721	Rebase mandibular partial denture	$75
D5730	Reline complete maxillary denture (chairside)	$60
D5731	Reline complete mandibular denture (chairside)	$60
D5740	Reline maxillary partial denture (chairside)	$60
D5741	Reline mandibular partial denture (chairside)	$60
D5750	Reline complete maxillary denture (laboratory)	$85
D5751	Reline complete mandibular denture (laboratory)	$85
D5760	Reline maxillary partial denture (laboratory)	$85
D5761	Reline mandibular partial denture (laboratory)	$85
D5810	Interim complete denture (maxillary)	$230
D5811	Interim complete denture (mandibular)	$230
D5820	Interim partial denture (maxillary)	$160
D5821	Interim partial denture (mandibular)	$170
D5850	Tissue conditioning, maxillary	$20
D5851	Tissue conditioning, mandibular	$20
D5862	Precision attachment, by report	$150
	Crowns/Fixed Bridges - Per Unit	
	• *An additional charge will be applied for any procedure using noble or high noble metal.*	
	• *Cases involving 7 or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.*	
D6210	Pontic – cast high noble metal	$245
D6211	Pontic – cast predominantly base metal	$245
D6212	Pontic – cast noble metal	$245
D6214	Pontic – titanium	$245
D6240	Pontic – porcelain fused to high noble metal	$245
D6241	Pontic – porcelain fused to predominantly base metal	$245
D6242	Pontic – porcelain fused to noble metal	$245
D6245	Pontic – porcelain/ceramic	$245
D6250	Pontic – resin with high noble metal	$245
D6251	Pontic – resin with predominantly base metal	$245
D6252	Pontic – resin with noble metal	$245

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D6253	Provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	$0
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$150
D6600	Retainer inlay – porcelain/ceramic, two surfaces	$245
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	$245
D6602	Retainer inlay – cast high noble metal, two surfaces	$245
D6603	Retainer inlay – cast high noble metal, three or more surfaces	$245
D6604	Retainer inlay – cast predominantly base metal, two surfaces	$245
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	$245
D6606	Retainer inlay – cast noble metal, two surfaces	$245
D6607	Retainer inlay – cast noble metal, three or more surfaces	$245
D6608	Retainer onlay – porcelain/ceramic, two surfaces	$245
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	$245
D6610	Retainer onlay – cast high noble metal, two surfaces	$245
D6611	Retainer onlay – cast high noble metal, three or more surfaces	$245
D6612	Retainer onlay – cast predominantly base metal, two surfaces	$245
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	$245
D6614	Retainer onlay – cast noble metal, two surfaces	$245
D6615	Retainer onlay – cast noble metal, three or more surfaces	$245
D6710	Retainer crown – indirect resin based composite	$245
D6720	Retainer crown – resin with high noble metal	$245
D6721	Retainer crown – resin with predominantly base metal	$245
D6722	Retainer crown – resin with noble metal	$245
D6740	Retainer crown – porcelain/ceramic	$245
D6750	Retainer crown – porcelain fused to high noble metal	$245
D6751	Retainer crown – porcelain fused to predominantly base metal	$245
D6752	Retainer crown – porcelain fused to noble metal	$245
D6780	Retainer crown – ¾ cast high noble metal	$245
D6781	Retainer crown – ¾ cast predominantly base metal	$245
D6782	Retainer crown – ¾ cast noble metal	$245
D6783	Retainer crown – ¾ porcelain/ceramic	$245
D6790	Retainer crown – full cast high noble metal	$245
D6791	Retainer crown – full cast predominantly base metal	$245
D6792	Retainer crown – full cast noble metal	$245
D6794	Retainer crown – titanium	$245
D6930	Re-cement or re-bond fixed partial denture	$0
D6940	Stress breaker	$110
D6950	Precision attachment	$150
D6980	Fixed partial denture repair necessitated by restorative material failure	$45
	Oral Surgery	
	• *Includes routine post operative visits/treatment.*	
	• *The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.*	
D7111	Extraction, coronal remnants – primary tooth	$5
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$30

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	and including elevation of mucoperiosteal flap if indicated	
D7220	Removal of impacted tooth – soft tissue	$50
D7230	Removal of impacted tooth – partially bony	$65
D7240	Removal of impacted tooth – completely bony	$80
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$100
D7250	Removal of residual tooth roots (cutting procedure)	$30
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$40
D7280	Exposure of an unerupted tooth	$100
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	$90
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$150
D7286	Incisional biopsy of oral tissue – soft	$60
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy – transepithelial sample collection	$50
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$40
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$15
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$45
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$25
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$25
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$35
D7520	Incision and drainage of abscess – extraoral soft tissue	$35
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$35
D7910	Suture of recent small wounds up to 5 cm	$25
D7960	Frenulectomy – aka frenectomy or frenotomy – separate procedure not incidental to another procedure	$50
D7963	Frenuloplasty	$50
D7970	Excision of hyperplastic tissue – per arch	$55
D7971	Excision of pericoronal gingiva	$40
	Orthodontics	
	• *Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.*	
	• *Comprehensive orthodontic benefits include all phases of treatment and fixed/removable appliances.*	

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D8010	Limited orthodontic treatment of the primary dentition	$1,000
D8020	Limited orthodontic treatment of the transitional dentition	$1,000
D8030	Limited orthodontic treatment of the adolescent dentition	$1,000
D8040	Limited orthodontic treatment of the adult dentition	$1,000
D8050	Interceptive orthodontic treatment of the primary dentition	25% Discount
D8060	Interceptive orthodontic treatment of the transitional dentition	25% Discount
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,850
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,850
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,850
D8210	Removable appliance therapy	25% Discount
D8220	Fixed appliance therapy	25% Discount
D8660	Pre-orthodontic treatment examination to monitor growth and development	$35
D8670	Periodic orthodontic treatment visit	$35
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8681	Removable orthodontic retainer adjustment	$0
D8693	Re-cement or re-bond fixed retainers	$0
D8999	Unspecified orthodontic procedure, by report Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250
•	Unspecified orthodontic procedure, by report Ortho visits beyond 24 months of active treatment or retention	$25 per visit
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$10
D9120	Fixed partial denture sectioning	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0
D9222	Deep sedation/general anesthesia – first 15 minutes	$60
D9223	Deep sedation/general anesthesia – each 15 minute increment	$60
D9230	Inhalation of nitrous oxide/ anxiolysis, analgesia	$15
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	$60
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$60
D9248	Non-intravenous conscious sedation	$15
D9310	Consultation – diagnostic service provided by dentist or physician other	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0
D9440	Office visit – after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic parenteral drug, single administration	$15
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$25
D9630	Drugs or medicaments dispensed in the office for home use	$15
D9910	Application of desensitizing medicament	$15

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D9942	Repair and/or reline of occlusal guard	$40
D9943	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$10
D9944	Occlusal guard – hard appliance, full arch	$85
D9945	Occlusal guard – soft appliance, full arch	$85
D9946	Occlusal guard – hard appliance, partial arch	$64
D9951	Occlusal adjustment – limited	$30
D9952	Occlusal adjustment – complete	$100
D9972	External bleaching – per arch - performed in office	$125
D9986	Missed appointment (less than 24-hr notice)	Not to exceed $25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0
D9999	Unspecified adjuctive procedure, by report	

Current Dental Terminology © American Dental Association

Dental Terminology Definitions

These definitions are designed to give you a “layman’s understanding” of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam: A silver filling

Anterior: Teeth that are in the front of the mouth

Bicuspid: Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.

Bridge: A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).

Crown: A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.

Endodontics: Procedures that treat the nerve or the pulp of the tooth due to injury or infection.

Oral Surgery: Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics: Braces and other procedures to straighten the teeth.

Periodontics: Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).

Exclusions and Limitations

Posterior:	Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).
Primary Teeth:	The first set of teeth (“baby” teeth).
Prophylaxis:	Scaling and polishing of teeth by removal of the plaque above the gum line.
Prosthodontics:	The restoration of natural and/or the replacement of missing teeth with artificial substitutes.
Quadrant:	One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).
Resin-based Composite:	Tooth-colored (white) fillings

Exclusions and Limitations

Limitations

General

1. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Preventive

1. Routine Cleanings (prophylaxis), periodontal maintenance services, and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the co-payment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.

2. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

Diagnostic

1. Panoramic or full-mouth X-rays: Once every three (3) years, unless medically necessary.

Restorative

1. An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal.

2. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.

3. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to the specified co-payment for each crown/bridge unit.

4. There is a $75 co-payment per crown/bridge unit in addition to the specified co-payment for porcelain on molars.

Prosthodontics

1. Relines are limited to one (1) every twelve (12) months.

2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard Plan, unless due to the loss of a natural functioning tooth. Replacements will be a benefit under this Plan only if the existing denture is unsatisfactory and cannot be made satisfactory as determined by the treating SafeGuard selected general dentist.

3. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

Endodontics

1. The co-payments listed for endodontic procedures do not include the cost of the final restoration.

Oral Surgery

1. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.

Exclusions and Limitations

General Exclusions

1. Services performed by any dentist not contracted with SafeGuard, without prior approval by SafeGuard (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.

2. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken.

3. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard selected general dentist.

4. Orthognathic surgery.

5. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.

6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect.

7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.

8. Procedures, appliances, or restorations whose primary main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.

9. Dental implants and services associated with the placement of implants, prosthodontics restoration of dental implants, and specialized implant maintenance services.

10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.

11. Dental services required while serving in the Armed Forces of any country or international authority.

12. Dental services considered experimental in nature.

13. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.

Exclusions and Limitations

Orthodontic Exclusions and Limitations

1. If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the member will be responsible for all costs associated with any orthodontic treatment.

2. If you terminate coverage from the SafeGuard Plan after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

3. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted orthodontist in order for the co-payments listed in the Schedule of Benefits to apply.

4. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of $25 dollars.

5. The following are not included as orthodontic benefits:

a). Repair or replacement of lost or broken appliances;

b). Retreatment of orthodontic cases;

c). Treatment involving:

1). Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;

2). Hormonal imbalances or other factors affecting growth or developmental abnormalities;

3). Treatment related to temporomandibular joint disorders;

4). Lingually placed direct bonded appliances and arch wires (“invisible braces”).

6. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

7. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.

MetLife | Dental Insurance

Find a participating Dentist in the Dental HMO/ Managed Care plan

The Dental HMO/Managed Care plan's network includes both private practice dentists and those who are in a clinic environment. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.

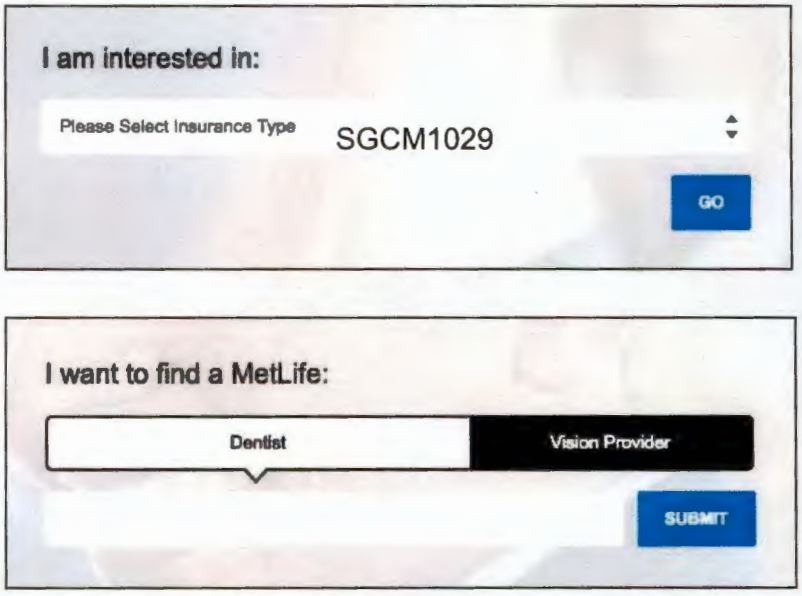
Step 1:
Go to metlife.com

Step 2:
Select "I want to find a MetLife:"

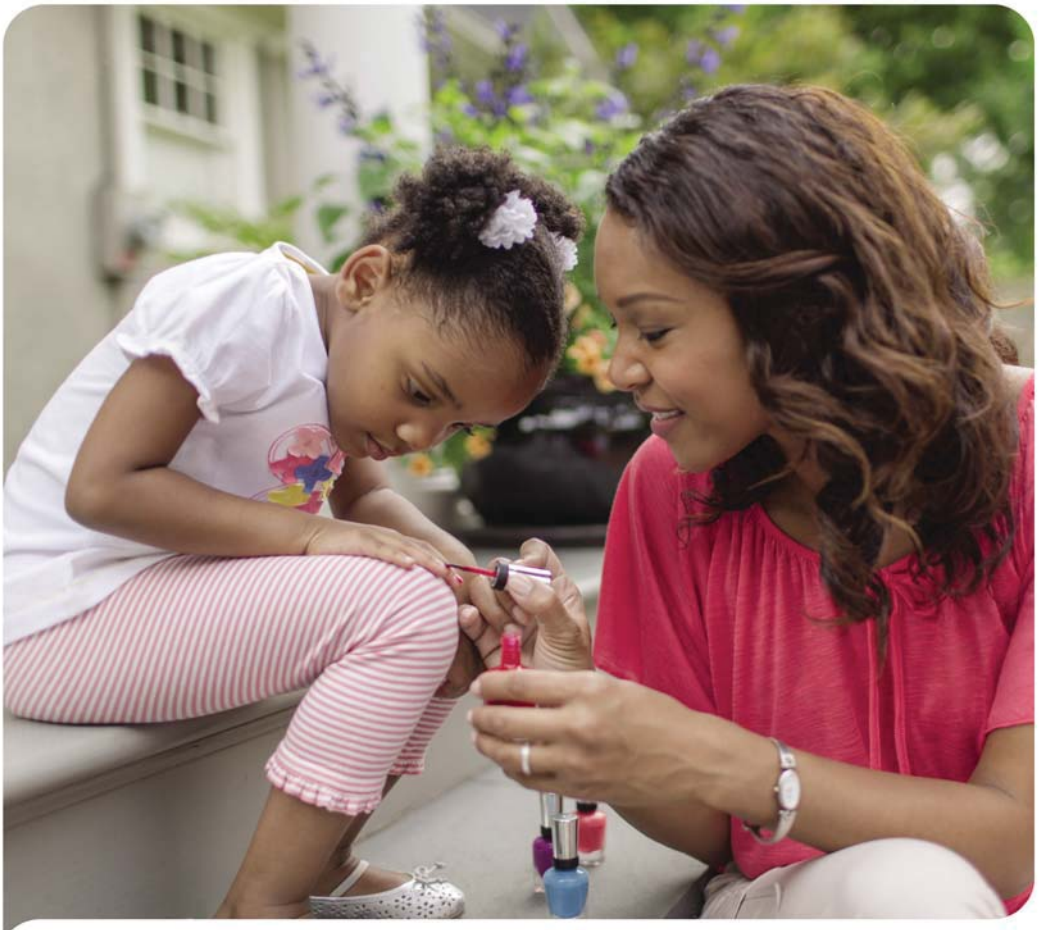
Click "Dentist" and enter your ZIP Code, and select the Dental HMO/Managed Care network.

Step 3:
Enter the Plan Name

The plan name is located in your Schedule of Benefits.



VISION INSURANCE



OPEN ENROLLMENT 2016 Summary of Benefits

Your Vision Benefits

City of Sunrise

Humana.

Humana.com

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Relationships are built on trust. Respect for an individual's privacy goes a long way toward building trust. Humana values our relationship with you, and we take your personal privacy seriously. Humana's Notice of Privacy Practices outlines how Humana may use or disclose your personal and health information. It also tells how we protect this information. The notice provides an explanation of your rights concerning your information, including how you can access this information and how to limit access to your information. In addition, it provides instructions on how to file a privacy complaint with Humana or to exercise any of your rights regarding your information.

If you'd like a copy of Humana's Notice of Privacy Practices, you can request a copy by:

- Visiting **Humana.com** and clicking the Privacy Practices link at the bottom of the home page
- E-mailing us at privacyoffice@humana.com
- Sending a written request to:
  Humana Privacy Office
  P.O. Box 1438
  Louisville, KY 40202

HumanaVision
Vision Care Plan

Florida

City of Sunrise

	See a participating provider	See a nonparticipating provider
Exam[1] with dilation as necessary	100% after $10 copay	$35 allowance
Lenses		
• Single	100% after $15 copay	$25 allowance
• Bifocal	100% after $15 copay	$40 allowance
• Trifocal	100% after $15 copay	$60 allowance
Frames	$50 wholesale allowance	$45 retail allowance
Contact lenses[2]		
• Elective (conventional and disposable)[3]	$150 allowance	$150 allowance
• Medically necessary (limit one pair)[4]	100%	$210 allowance
Frequency (based on date of service)		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months

Additional plan discounts

- Members may benefit with fixed pricing for most lens options including anti-reflective and scratch-resistant coatings.
- Members may also be eligible to receive up to a 20 percent retail discount on a second pair of eyeglasses, which is available for 12 months after the covered eye exam through the participating provider who sold the initial pair of eyeglasses.
- After copay, standard polycarbonate available at no charge for dependents less than 19 years old.

[1] Material copay is required for a complete pair of eyeglasses, lenses or frames.

[2] If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames) (Vision Care Plan only).

[3] The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members may be eligible to receive up to a 15 percent discount on in-network professional services, which is available for 12 months after the covered eye exam.

[4] Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior plan authorization.

Vision Care Plan

HumanaVision Lasik discount

We have contracted with many well-known facilities and eye doctors to offer Lasik procedures at substantially reduced fees. You can take advantage of these low fees when procedures are done by network providers. The network locations listed below offer the following prices (per eye):

	Conventional / Traditional**		Custom**	
TLC 888-358-3937 (designated locations only)	**$895**		**$1,295**	**$1,895***
Lasik*Plus* 866-757-8082	**$695*** Lasik*Plus* free enhancements for 1 year	**$1,395*** Lasik*Plus* free enhancements for life	**$1,895*** Lasik*Plus* free enhancements for life	
QualSight LASIK 855-456-2020	**$895** QualSight free enhancements for 1 year	**$1,295** with QualSight Lifetime Assurance Plan	**$1,320**	**$1,995*** with QualSight Lifetime Assurance Plan

You may receive a 10% discount from retail prices at certain independent Lasik participating providers and pay no more than $1,800 per eye for Conventional Lasik and $2,300 per eye for Custom Lasik.

*with IntraLase™

**Pricing varies by section procedure offered by the provider you choose and options in your area. Not all locations offer fixed pricing. Please call the provider for details

How does the wholesale frame allowance work?

Benefits include a wholesale frame allowance. If the wholesale cost exceeds the frame allowance, members pay twice the wholesale difference. They never pay full retail.

Retail price*	Wholesale price	Wholesale allowance	Member pays	Savings
$125	$50	$50	$0	$125
$187.50	$75	$50	$50 ($75-$50=$25x2=$50)	$137.50

* Retail costs may differ and are based on 2½ times the wholesale cost. Actual savings may vary.

Use your HumanaVision benefits

HumanaVision options have you covered and make eye care affordable. You have access to one of the largest vision networks in the United States, with more than 35,000 participating optometrist, ophthalmologists, and national retail locations, including LensCrafters®, Pearle Vision®, Sears® Optical, Target® Optical, and JCPenney® Optical. In addition you'll enjoy:

- The same benefits at all participating providers, no matter where they're located
- Wholesale pricing on frames, avoiding high retail markups
- Simple access to plan information, provider search, Customer Care and other automated services at **HumanaVisionCare.com**

How it Works

1. After signing up for your vision plan, you will receive an ID card in the mail
2. Prior to scheduling your appointment, select a network provider through the Customer Care Center, automated information line, or **HumanaVisionCare.com**
3. Schedule an appointment, providing your name, the patient's name and employer
4. Sign your provider's form after your exam, you'll pay any copayments and/or costs of any upgrades at this time

PRIVATE PRACTITIONERS LENSCRAFTERS PEARLE VISION JCPenney Optical Sears Optical TARGET OPTICAL

Know what your plan covers

Attached is a summary of HumanaVision benefits that are described in detail in your certificate. You can find your certificate on **HumanaVisionCare.com** or call 1-866-537-0229. Here's what you can expect:

- Quality routine eye health care from independent eye care professionals and national retail locations.
- Services and materials provided on a prepaid basis, and the plan pays in-network providers directly, you also have the freedom to use out-of-network providers if you prefer
- Life without claim forms! With HumanaVision, you pay your eye care professional directly for copayments and any extra cosmetic options selected at the time of service
- Select a vision provider from our network simply by visiting **HumanaVisionCare.com**, if you prefer, call us at 1-866-537-0229

Know what your plan doesn't cover

Some items and services not included in HumanaVision are:

- Orthoptics or vision training, subnormal vision aids or Plano (non-prescription) lenses
- Replacement of lost or broken lenses, except at the regularly-scheduled plan intervals
- Medical or surgical treatment of eyes
- Care provided through or required by any government agency or program, including Workers' Compensation or a similar law

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.[1]

[1] Thompson Media Inc.

This is not a complete disclosure of plan qualifications and limitations.

Check with your local Humana or HumanaDental sales office to verify product availability.

Insured by Humana Insurance Company or CompBenefits Insurance Company or CompBenefits Company

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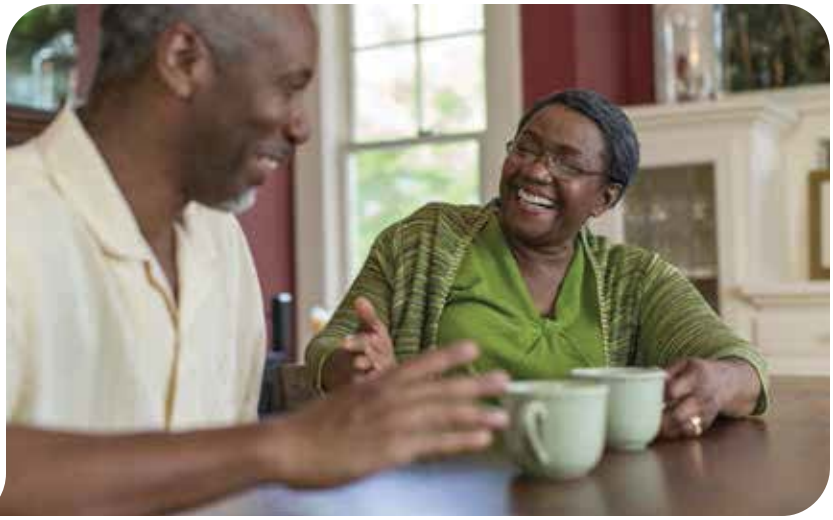
Humana Vision Care Plan (VCP): how it works



With Humana VCP options, employees gain access to one of the largest networks in the United States, with more than 35,000 provider locations including independent optometrists and ophthalmologists as well as the five largest retail stores in the nation - Target®, Sears®, JCPenney®, Lenscrafters® and Pearle Vision℠. They also save on examinations, frames, lenses or contact lenses, and popular lens options.

Example 1: Sarah – single coverage, VCP plan

- $10 exam copayment
- $15 standard lenses copayment
- $50 wholesale frame allowance
- $150 contact lens allowance
- Frequencies:
  - Examination: once every 12 months
  - Lenses or contact lenses: once every 12 months
  - Frames: once every 24 months

Sarah goes to her optometrist for an eye exam:

- Exam with dilation as necessary: $79 - $119
- Sarah pays exam copayment: $10
- **Savings on exam: $69 – $109**

Case study:

Sarah's vision expenses for the year totaled $379 – $469 without Humana VCP.
With vision coverage, Sarah paid $56 for an exam and single-vision eyeglasses with standard scratch-resistant coating and standard UV coating. She saved $323 – $413, more than 80 percent of the total retail cost.

	RETAIL COST[1]	MEMBER COST	MEMBER SAVINGS
$50 wholesale frame allowance	$150[2]	$0	$150
Single-vision standard lenses	$70-$120	$15	$55-$105
Standard scratch-resistance coating	$40	$16	$24
Standard UV coating	$40	$15	$25
Total savings	**$300-$350**	**$46**	**$254-304**

[1] Based on national average. Average retail costs may vary by provider and location.
[2] Frame retail cost based on three times the wholesale cost
Examples are for illustration only. Actual savings may vary.

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Example 2: Sam – single coverage, VCP plan

- $10 exam copayment
- $15 standard lenses copayment
- $50 wholesale frame allowance
- $150 contact lens allowance
- Frequencies:
  - Examination: once every 12 months
  - Lenses or contact lenses: once every 12 months
  - Frames: once every 24 months

Sam goes to his optometrist for an eye exam:

- Exam with dilation as necessary: $79 - $119
- Sam pays exam copayment: $10
- Savings on exam: $69 – $109

Case study:

Sam's vision expenses for the year totaled $873 – $913 without Humana VCP. With vision coverage, Sam paid $337 for an exam; frames; Varilux Comfort® (premium progressive lenses); Crizal Avancé™ with Scotchguard™ protector and Transitions® lenses, a photochromic tint. He saved $558 – $598, more than 65 percent of the total retail cost.

	RETAIL COST[1]	WHOLESALE COST	WHOLESALE ALLOWANCE	MEMBER PAYS[2]	SAVINGS WITH VCP
Frames	$225	$75	$50	($25x2)=$50	$175

	RETAIL COST[3]	MEMBER COST	MEMBER SAVINGS
Varilux Comfort® (premium progressive lenses)	$250	$94	$168
Crizal Avancé™ with Scotchguard Protector	$199	$105	$114
Transitions® lenses (photochromic tint)	$120	$88	$32
Total	**$569**	**$287**	**$314**
Frames (see chart above)	$225	$50	$175
	$794	**$337**	**$489**

[1] Frame retail cost based on three times the wholesale cost.
[2] Member pays twice the difference between the wholesale price and wholesale allowance.
[3] Based on national average. Average retail costs may vary by provider and location. Examples are for illustration only. Actual savings may vary.

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Vision products insured by Humana Insurance Company or CompBenefits Insurance Company

GN52359HV 1213

Humana Vision Lasik

Opening doors to better vision for thousands of people – with affordable Lasik[1] procedures

Network doctors can help you understand these new procedures and provide access to our network of Lasik providers.

You may also use independent Lasik provider network doctors to receive a 10% discount from usual and customary prices and pay no more than $1,800 per eye for Conventional Lasik and $2,300 per eye for Custom Lasik due to SB632.

[1] Laser-assisted in-situ keratomileusis

[2] If qualified as a Lasik candidate by the network doctor

The Lasik program is a discount only for Humana Vision members and is not a covered benefit.

Insured by Humana Insurance Company or CompBenefits Insurance Company, or The Dental Concern, Inc.

Reduced fees

Lasik procedures are available if you are nearsighted or have astigmatism and wear glasses or contacts.[2] We have contracted with many well-known facilities and eye doctors to offer these procedures at substantially reduced fees.

You can take advantage of these low fees when procedures are done by network providers. The network locations listed below offer the following prices (per eye):

	Custom**
TLC 888-358-3937	**$1,295** **$1,895***
Lasik*Plus* 866-757-8082	**$1,895*** Lasik*Plus* free enhancements for life
QualSight LASIK 855-456-2020	**$1,320** **$1,995*** with QualSight Lifetime Assurance Plan

*with IntraLase™

**Pricing varies by section procedure offered by the provider you choose and options in your area. Not all locations offer fixed pricing. Please call the provider for details.

Easy access to service

During your comprehensive eye health examination, your doctor can determine if you are a candidate for Lasik. If you qualify, the doctor can also make arrangements for the procedure with one of the centers that participates in this program.

Your Humana Vision ID card verifies your eligibility for Lasik discounts. You can obtain a list of providers from our website, **HumanaVisionCare.com** or by calling a Customer Care Specialist at 866-537-0229.

This discount cannot be combined with any other discount or promotional offer. The Humana Vision Lasik program is not affiliated with any medical or health plan. All pricing listed is per eye.

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Notice of Privacy Practices
For your personal health and financial information

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.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written and oral information.

How do we protect your information?

In keeping with federal and state laws and our own policy, we have a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How do we use and disclose your information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you if you have not opted out as described below
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill our obligations under any workers' compensation law or contract

Notice of Privacy Practices
(continued)

- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?

In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require an authorization:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of protected health information

What do we do with your information when you are no longer a member or you do not obtain coverage through us?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information. We are committed to responding to your rights request in a timely manner.

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision – You have the right to be provided a reason for denial or adverse underwriting decision if your application for insurance is declined. *
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

What types of communications can I opt out of that are made to me?

- Appointment reminders
- Treatment alternatives or other health-related benefits or services

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at Humana.com and going to the Privacy Practices link

* This right applies only to our Massachusetts residents in accordance with state regulations.

Notice of Privacy Practices
(continued)

- E-mailing us at privacyoffice@humana.com
  Send completed request form to:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

What will happen if my private information is used or disclosed inappropriately?

You have a right to receive a notice that a breach has resulted in your unsecured private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

We and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How do we collect information about you?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will we disclose your information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by us or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell us not to share any of your personal information with affiliated companies that provide offers other than our products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com.
- Send your opt-out request to us in writing:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws,

Notice of Privacy Practices
(continued)

rules, and regulations conflict, we follow the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to our privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company
CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc. dba LifeSynch
CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.
Humana MarketPOINT of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership, Inc.*
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

Humana®

Vision Care Plan

Provider options price list — effective April 28, 2014

Options	Comments	Total Payment to Provider from Patient				Total Chargeback from Provider	
		Code	Single Vision (SV)	Code	Multifocal	Single Vision (SV)	Multifocal
Nonaspheric styles	10						
Mid-index 1.53–1.59		H1	48	H2	55	33	40
High-index 1.60–1.66		I1	55	I2	64	40	48
High-index 1.67–1.70		H5	95	H6	112	47	85
High-index 1.71–1.74		H9	120	H10	130	90	95
* Trivex®/Trilogy®/TREXA™		H3	48	H4	55	33	40
* Phoenix		PHX1	45	PHX2	55	28	40
Polycarbonate (age 19 and higher)	5	B1	28	B2	32	16	20
Polycarbonate (under age 19)	5	B1C	N/C	B2C	N/C	N/C	N/C
* Glass 1.523 standard index	10	GL1	N/C	GL2	N/C	N/C	N/C
High-index glass		C1	36	C2	91	22	61
Aspheric styles	1, 8						
Regular plastic		E1	45	E2	56	30	41
Polycarbonate		E3	49	E4	56	34	41
Mid-index 1.53–1.59		E5	48	E6	55	33	40
High-index 1.60–1.66		I5	68	I6	77	48	57
High-index 1.67–1.70		I7	107	I8	115	62	90
High-index 1.71–1.74		N1	135	N2	154	100	109
* Trivex/Trilogy/TREXA		H7	48	H8	55	33	40
* Phoenix		PHXA1	48	PHXA2	55	33	40
Polarized styles							
Polarized plastic		F3	61	F4	71	41	46
Polarized mid-/high-index		F5	99	F6	124	53	56
Polarized polycarbonate		F7	78	F8	101	51	53
Polarized glass		F1	65	F2	86	54	73
Xperio UV® (Crizal backside AR is automatically included) Charge in addition to appropriate material	12	XPUV1	145	XPUV2	145	95	95
Xperio UV Mirrors (Crizal backside AR is automatically included) Charge in addition to appropriate material	12	XPUVM1	165	XPUVM2	165	105	105
Progressive lens styles	3, 8						
*** Level 1 progressive**							
Essilor Adaptar®		—	—	L1EADP	60	—	30
Essilor Super No-Line®		—	—	L1ESNL	60	—	30
Rodenstock Life SI		—	—	L1RLSI	60	—	30
Signet Armorlite S/A Navigator®		—	—	L1SN	60	—	30
S/A Navigator Short®		—	—	L1SNS	60	—	30
Sola Instinctive™		—	—	L1SINS	60	—	30
Vision-Ease Outlook®		—	—	L1VOU	60	—	30
Younger Image®		—	—	L1YIMG	60	—	30
*** Level 2 progressive**							
AO Compact®		—	—	L2ACMP	71	—	41
Essilor Adaptar® Digital		—	—	L2EAD	71	—	41
Essilor Adaptar Short Digital		—	—	L2EASD	71	—	41
Essilor Natural®		—	—	L2ENAT	71	—	41
Essilor Natural Digital		—	—	L2END	71	—	41
Hoyalux GP		—	—	L2HGP	71	—	41
Kodak Concise®		—	—	L2KC	71	—	41
Seiko AF2		—	—	L2SAF2	71	—	41
SOLAMAX™		—	—	L2SMAX	71	—	41
Sola VIP		—	—	L2SVIP	71	—	41
Vision-Ease Illumina®		—	—	L2VILL	71	—	41
X-Cel Freedom ID™		—	—	L2XFID	71	—	41
*** Level 3 progressive**							
AO Easy		—	—	L3AEZ	82	—	42
Essilor Ideal™		—	—	L3EI	82	—	42
Essilor Ovation®		—	—	L3EOVA	82	—	42
Essilor Ovation Digital		—	—	L3EOD	82	—	42

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Options	Comments	Total Payment to Provider from Patient				Total Chargeback from Provider	
		Code	Single Vision (SV)	Code	Multifocal	Single Vision (SV)	Multifocal
Essilor Smallfit™		—	—	L3ESF	82	—	42
Essilor Smallfit Digital		—	—	L3ESD	82	—	42
Hoyalux GP Wide		—	—	L3HGPW	82	—	42
Kodak Precise®		—	—	L3KP	82	—	42
Kodak Precise PB	17	—	—	L3KPB	82	—	42
Kodak Precise Short	17	—	—	L3KPS	82	—	42
Kodak Precise Short PB		—	—	L3KPBS	82	—	42
Rodenstock Classic Life		—	—	L3RCL	82	—	42
Rodenstock Classic Life XS		—	—	L3RCLX	82	—	42
Seiko Succeed		—	—	L3SS	82	—	42
Seiko Succeed WS		—	—	L3SSWS	82	—	42
Level 4 progressive							
AO B'Active™		—	—	L4ABAC	94	—	50
Essilor Accolade®		—	—	L4EAC	94	—	50
Essilor Ideal Short		—	—	L4EIS	94	—	50
Hoya Summit cd		—	—	L4HSC	94	—	50
Hoya Summit ecp		—	—	L4HSE	94	—	50
KBCo Fusion 1™		—	—	L4BFU1	94	—	50
KBCo Fusion II™		—	—	L4BFU2	94	—	50
Optima Hyperview		—	—	L4OHYP	94	—	50
* Seiko Supercede		—	—	L4SSPC	94	—	50
Shamir Creation®		—	—	L4HCRE	94	—	50
* Shamir Element™		—	—	L4HELM	94	—	50
Shamir Genesis®		—	—	L4HG	94	—	50
Shamir Piccolo®		—	—	L4HPC	94	—	50
Shamir Piccolo Attitude®		—	—	L4HPCA	94	—	50
Sola Compact Ultra™		—	—	L4SCU	94	—	50
Varilux® Ellipse®		—	—	L4VE	94	—	50
Varilux Comfort®		—	—	L4VC	94	—	50
Varilux Comfort DRx		—	—	L4VCDR	94	—	50
Varilux Comfort Short		—	—	L4VCS	94	—	50
Varilux Comfort Short DRx		—	—	L4VCSD	94	—	50
Varilux Sport™		—	—	L4VSPT	94	—	50
* Vision-Ease Novel®		—	—	L4VNV	94	—	50
* Vision-Ease Novella®		—	—	L4VNVA	94	—	50
Level 5 progressive							
Definity®		—	—	L5EDF	135	—	90
Definity Short		—	—	L5EDFS	135	—	90
Essilor Accolade Freedom™		—	—	L5EACF	135	—	90
Essilor Ideal Advanced™		—	—	L5EIA	135	—	90
Essilor Ideal Advanced Wrap™		—	—	L5EIAW	135	—	90
Hoya Summit cd iQ		—	—	L5HSCI	135	—	90
Hoya Summit ecp iQ		—	—	L5HSEI	135	—	90
Kodak Concise Digital		—	—	L5KDC	135	—	90
Kodak Precise Digital		—	—	L5KDP	135	—	90
Kodak Precise Short Digital		—	—	L5KDPS	135	—	90
* Seiko Supernal		—	—	L5SSPN	135	—	90
Shamir FirstPAL™		—	—	L5SFP	135	—	90
* Shamir InTouch™		—	—	L5HI	135	—	90
Shamir Spectrum™		—	—	L5HS	135	—	90
Varilux Ellipse 360		—	—	L5VE36	135	—	90
Varilux Comfort Enhanced™		—	—	L5VCE	135	—	90
Varilux™ Physio™		—	—	L5VP	135	—	90
Varilux Physio DRx		—	—	L5VPD	135	—	90
Varilux Physio Short		—	—	L5VPS	135	—	90
Varilux Physio Short DRx		—	—	L5VPSD	135	—	90
Level 6 progressive							
Definity 3		—	—	L6EDF3	145	—	95
Hoya iD LifeStyle		—	—	L6HLID	145	—	95
Hoya iD LifeStyle cd		—	—	L6HLIC	145	—	95
* Hoyalux Array	15	—	—	L6HAR	145	—	95
* Hoyalux Array High Base	15	—	—	L6HARH	145	—	95
Kodak Unique	17	—	—	L6KU	145	—	95
* Seiko Surmount		—	—	L6SSM	145	—	95

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Options	Comments	Total Payment to Provider from Patient				Total Chargeback from Provider	
		Code	Single Vision (SV)	Code	Multifocal	Single Vision (SV)	Multifocal
* Seiko Surmount WS		—	—	L6SSMW	145	—	95
Shamir Autograph II®		—	—	L6HA	145	—	95
Shamir Autograph II-Attitude™		—	—	L6HAA	145	—	95
Shamir Golf™		—	—	L6HG	145	—	95
Varilux Physio 360		—	—	L6VP3	145	—	95
Varilux Physio Enhanced		—	—	L6VPE	145	—	95
Varilux Physio Short 360		—	—	L6VPS3	145	—	95
* Varilux Stylistic Wrap	16	—	—	L6VSW	145	—	95
Level 7 progressive	for internal use only						
Level 8 progressive							
Definity 3 Plus		—	—	L8EDFP	185	—	124
* Hoya iD InStyle™		—	—	L8HDI	185	—	124
* Hoya iD LifeStyle Clarity™		—	—	L8HDLC	185	—	124
* Hoya iD LifeStyle Harmony™		—	—	L8HDLH	185	—	124
* Shamir Autograph III®		—	—	L8HA3	185	—	124
Varilux Ipseo IV™		—	—	L8VI4	185	—	124
Varilux Ipseo IV eyecode™		—	—	L8VI4E	185	—	124
Varilux Physio Enhanced Azio™		—	—	L8VPEA	185	—	124
Varilux Physio Enhanced eyecode™		—	—	L8VPEE	185	—	124
Varilux Physio Enhanced Fit™		—	—	L8VPEF	185	—	124
Varilux Physio Enhanced India™		—	—	L8VPEI	185	—	124
Level 9 progressive	for internal use only						
Level 10 progressive	for internal use only						
Level 11 progressive							
* Hoya iD MyStyle		—	—	L11HDM	270	—	185
Varilux S Design		—	—	L11VS	270	—	185
Varilux S Design Short		—	—	L11VSS	270	—	185
Varilux S Fit		—	—	L11VSF	270	—	185
Varilux S 4D™		—	—	L11VS4	270	—	185
*** Near-variable lens styles**	3, 8						
Level A near-variable							
Essilor Computer™		—	—	D2ECPR	49	—	24
Essilor Interview		—	—	D2EINT	49	—	24
Hoya TACT		—	—	D2HTCT	49	—	24
Shamir Office		—	—	D2HOFC	49	—	24
Sola Access		—	—	D2SA	49	—	24
Level B near-variable							
Shamir Autograph II-Office™		—	—	D2HA2O	80	—	55
Anti-reflective (AR) coating products							
Standard							
* Seiko Surpass ECP		R1SS	44	R2SS	44	26	26
Sharpview Plus		R1ESP	44	R2ESP	44	26	26
Standard AR 1 year		R1SAR	44	R2SAR	44	26	26
Premium							
Hoya HiVision		P5HHV	60	P6HHV	60	38	38
Hoya Premium AR		P5HP	60	P6HP	60	38	38
Hoya Premium with View Protect		P5HPVP	60	P6HPVP	60	38	38
Kodak CleAR		P5KCL	60	P6KCL	60	38	38
* Seiko Super Surpass ECP		P5SSS	60	P6SSS	60	38	38
Elite							
Crizal Easy UV™	4, 14	P3ECEZ	72	P4ECEZ	72	49	49
Hoya HiVision with View Protect		P3HHVP	72	P4HHVP	72	49	49
Supreme							
Crizal Alizé UV™	4, 14	P7ECAZ	85	P8ECAZ	85	61	61
Hoya Super HiVision		P7HSHV	85	P8HSHV	85	61	61
Kodak Clean'N'CleAR		P7KCNC	85	P8KCNC	85	61	61
Diamond							
Crizal Avancé UV™	4, 14	P9ECAV	105	P0ECAV	105	73	73
Crizal SunShield UV™	4, 14	P9ECS	105	P0ECS	105	73	73
Crizal SunShield UV™ Mirrors	4, 14	P9ECSM	105	P0ECSM	105	73	73
* Hoya Recharge		P9HRC	105	P0HRC	105	73	73
Hoya Super HiVision EX3		P9HEX3	105	P0HEX3	105	73	73
Imperial							
* Crizal Prevencia™	4, 14	IECP1	130	IECP2	130	84	84
Crizal Sapphire UV™	4, 14	IECSP1	130	IECSP2	130	84	84
Crizal UV with Optifog™ Technology	4, 14	IECOF1	130	IECOF2	130	84	84

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Options	Comments	Total Payment to Provider from Patient				Total Chargeback from Provider	
		Code	Single Vision (SV)	Code	Multifocal	Single Vision (SV)	Multifocal
Specialty lenses	11						
*** Crizal Kids UV™**	13						
Polycarbonate (Crizal AR is automatically included)		ECKUV	55	—	—	28	—
Essilor 360 SV™ Aspheric							
Polycarbonate		K11	68	—	—	47	—
High-index 1.67		K13	102	—	—	70	—
High-index 1.74		K15	169	—	—	115	—
Essilor Azio SV™ Aspheric							
Polycarbonate		K31	78	—	—	54	—
High-index 1.67		K33	112	—	—	77	—
High-index 1.74		K35	179	—	—	122	—
Essilor eyecode™ SV Aspheric							
Polycarbonate		K41	82	—	—	56	—
High-index 1.67		K43	115	—	—	79	—
High-index 1.74		K45	183	—	—	125	—
Essilor FIT™ SV Aspheric							
Polycarbonate		K21	78	—	—	54	—
High-index 1.67		K23	112	—	—	77	—
High-index 1.74		K25	179	—	—	122	—
*** Essilor Stylistic™ WRAP SV**							
1.50 Plastic Polarized		ESWPPZ	152	—	—	96	—
Polycarbonate Polarized		ESWYPZ	175	—	—	110	—
Polycarbonate Colors (nonpolarized)		ESWYC	116	—	—	73	—
High-index 1.67 Polarized		ESW7PZ	275	—	—	176	—
Hoya ID SV							
High-index 1.60		HID60	145	—	—	89	—
High-index 1.67		HID67	165	—	—	109	—
High-index 1.70		HID70	177	—	—	121	—
Hoya ST28 IQ							
Plastic		—	—	HQ28PL	80	—	53
Polycarbonate		—	—	HQ28PC	85	—	54
Polycarbonate Polarized		—	—	HQ28PP	185	—	121
Trivex		—	—	HQ28X	99	—	69
Hoya SV IQ							
Plastic		HQSPL	63	—	—	43	—
Polycarbonate		HQSPC	68	—	—	47	—
Polycarbonate Polarized		HQSPCP	135	—	—	90	—
Trivex		HQSX	88	—	—	55	—
Trivex Polarized		HQSXP	140	—	—	94	—
High-index 1.67		HQS67	121	—	—	89	—
*** Hoyalux Array Sync™ 5**							
Plastic		HS5PL	73	—	—	44	—
* Phoenix		HS5X	80	—	—	50	—
High-index 1.60		HS560	87	—	—	57	—
High-index 1.67		HS567	108	—	—	68	—
*** Hoyalux Array Sync 8**							
Plastic		HS8PL	73	—	—	44	—
* Phoenix		HS8X	80	—	—	50	—
High-index 1.60		HS860	87	—	—	57	—
High-index 1.67		HS867	108	—	—	68	—
Plastic tints							
Solid tint (excludes pink and rose)	9	T1	13	T2	13	7	7
Gradient tint		T5	15	T6	15	8	8
Glass tints and others							
Tinted glass (excludes pink and rose)		G4	18	G5	27	12	21
Glass tint yellow		G6	50	G7	67	35	52
Glass coating solid		T3	27	T4	31	21	25
Glass coating gradient		T7	27	T8	31	21	25
Photochromics	6						
Glass PBX or PGX		A1	23	A2	34	10	20
Glass Thin & Dark		A3	37	A4	58	17	38
* Plastic A: SunTech		PHPASV	72	PHPAMF	83	32	42
* Plastic B: Transitions®, PhotoViews™, LifeRx®, ChangeRx®, Colormatic®		PHPBSV	77	PHPBMF	88	36	46
* Plastic C: XTRActive®		PHPCSV	115	PHPCMF	125	73	80
* Plastic D: Transitions® Vantage™		PHPDSV	120	PHPDMF	157	75	105

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Options	Comments	Total Payment to Provider from Patient				Total Chargeback from Provider	
		Code	Single Vision (SV)	Code	Multifocal	Single Vision (SV)	Multifocal
Miscellaneous							
Blended bifocal	8	—	—	M2	49	—	32
Mirror coating solid or gradient		V1	44	V2	44	28	28
Factory scratch-resistant coating	7	S1	16	S2	16	6	6
Premium scratch-resistant coating							
Essilor TD2®		S3ETD2	29	S4ETD2	29	15	15
Essilor TD2 with Optifog™ Technology		S3ETDO	48	S4ETDO	48	34	34
Hoya Clarity Shield		S3HCS	29	S4HCS	29	15	15
Oversize 61 and above	8	Z1	14	Z2	14	6	6
Facet (includes polishing)		Y1	58	Y2	64	39	45
Ultraviolet (UV) treatment	4	U1	15	U2	15	8	8
* Blu-Tech	4, 17	—	—	BTEC2	20	—	13
Groove		X3	12	X4	12	5	5
Drill and/or notch	2	X5	27	X6	27	20	20
Roll and polish/polish edges/edge coating		X1	13	X2	13	6	6
Occupational/double segment		—	—	—	N/C	—	N/C
Executive bifocal (plastic only)		—	—	—	N/C	—	N/C
Center thickness 1.5 or below		—	N/C	—	N/C	N/C	N/C
Slab-off		—	N/C	—	N/C	N/C	N/C
Prism		—	N/C	—	N/C	N/C	N/C

Comments

1. The member's materials copayment covers single-vision or 22mm round-segment, aspheric-lenticular lenses at no additional payment. (Cataract/Aphakic)
2. To allow the best performance against cracking, splitting or chipping, Vision Care Plan strongly recommends the use of polycarbonate or trivex materials for all drill- or notch-mount frames. Use of any other material for these styles of frames may void any warranty from the laboratory.
3. Some progressive lenses are limited to certain materials, index and anti-reflective options. Confirm availability with your lab prior to submitting order.
4. Ultraviolet (UV) treatment: You may not select the ultraviolet treatment option in conjunction with photochromic, polarized, Blu-Tech, polycarbonate or mid- or high-index lenses. You may, however, select any Crizal UV anti-reflective product, including Crizal Prevencia, if your patient chooses to purchase one of these options. All Crizal anti-reflective coating products provide maximum UV protection.
5. Do not collect a patient payment for the B1 or B2 option if member is under age 19. Qualifying members receive these options at no additional payment.
6. VCP covers photochromics as listed by name on the price list. Other photochromics not listed by name, including Corning CPF Series lenses, are not covered by Vision Care Plan. If medically necessary, follow the procedure for prior authorization.
7. Factory scratch-resistant coating: Do not charge on polycarbonate, trivex, glass, mid- or high-index materials or progressive or AR-coated lenses.
8. Oversize and aspheric: Do not charge for these options on progressive or blended-style lenses.
9. Pink and Rose 1 and 2 solid tints are always covered.
10. The member's materials copayment covers single-vision, lined bifocal or lined trifocal lenses that are clear and nonaspheric and are made of standard glass or standard plastic.
11. Specialty lenses are available in a select range of materials and in select photochromic and anti-reflective options. Confirm availability with your lab prior to submitting order.
12. The Xperio UV and Xperio UV Mirror options automatically include unique ultraviolet (UV) treatment and Crizal backside AR components. Do not charge for, or make separate selections of, UV, any Crizal AR or mirror coating. Charge for Xperio UV options in addition to the appropriate material option.
13. The Crizal Kids UV lens option automatically includes unique ultraviolet (UV) treatment and Crizal anti-reflective (AR) components. Do not charge for, or make separate selections of, UV or any Crizal AR.
14. All Crizal anti-reflective coating products provide maximum ultraviolet protection. Do not charge for, or make a separate selection of, the ultraviolet treatment option.
15. Locate Hoyalux Array Sync 5 and 8 vertical aspheric design lenses in the specialty lenses section.
16. For Polarized Varilux Stylistic Wrap lenses, also charge for the appropriate option in the polarized styles section of the price list. For polycarbonate colors (nonpolarized), add a charge for nonaspheric style in polycarbonate, plus a solid tint.
17. VCP currently offers Blu-Tech Indoor and Outdoor availability only for select Kodak progressive lenses. For Blu-Tech Indoor lenses, charge for the Blu-Tech option in the miscellaneous section of the price list. For Blu-Tech Outdoor lenses, also charge for the appropriate option in the polarized styles section of the price list. You may not select the ultraviolet treatment option in conjunction with Blu-Tech.

Please note: Prices are subject to change.

LIFE INSURANCE

Standard Insurance Company
City of Sunrise
Group Policy #755780

Group Additional Life Insurance

Help protect your loved ones from financial hardship.

This coverage is designed to help provide financial support and stability to your family should you pass away. You can also cover your eligible spouse and child(ren). Life insurance is an easy, responsible way to help protect your family from financial hardship during a difficult time — and into the future.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits if you become terminally ill or die
- A special Guarantee Issue enrollment opportunity this year. See Open Enrollment section for additional details.

About This Coverage

If you take no action you'll be covered under Basic Life insurance provided you meet the eligibility requirements. Consider whether that would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund your children's education. If not, you may want to apply for additional coverage now.

How Much Can I Apply For? Your combined Basic Life and Additional Life amounts cannot exceed a maximum of 6 times your annual earnings. The coverage amount for your spouse cannot exceed 50 percent of your Additional Life coverage. The coverage amount for your child(ren) cannot exceed 50 percent of your Additional Life coverage.	For You:	**$10,000 – $500,000** in increments of **$10,000**
	For Your Spouse:	**$5,000 – $250,000** in increments of **$5,000**
	For Your Child(ren):	**$2,500 – $10,000** in increments of **$2,500**
What is the Guarantee Issue Maximum? Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.	For You:	Up to **$300,000**
	For Your Spouse:	Up to **$50,000**

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Upon Hire

For You. If you are currently enrolled in Additional Life insurance for an amount less than $300,000, you may elect to increase your coverage by $10,000, up to, but not to exceed, the guarantee issue amount of $300,000 without having to secure medical underwriting approval. If you are not currently enrolled in Additional Life insurance, you may elect coverage by $10,000 without having to secure medical underwriting approval.

For Your Spouse. If your spouse is currently enrolled in Dependents Life insurance for an amount less than $50,000, you may elect to increase coverage by $5,000, up to, but not to exceed, the guarantee issue amount of $50,000 without having to secure medical underwriting approval. If your Spouse is not currently enrolled in Dependents Life insurance, you may elect coverage by $5,000 without having to secure medical underwriting approval.

For Your Child(ren). If your child(ren) is/are currently enrolled in Dependents Life insurance for an amount less than $10,000, you may elect to increase coverage by $2,500, up to the maximum coverage amount of $10,000 without having to secure medical underwriting approval. If your child(ren) is/are not currently enrolled in Dependents Life insurance, you may elect coverage up to the maximum coverage amount of $10,000 without having to secure medical underwriting approval.

Additional Feature

Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

How much Life insurance do you need?
After a death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Burial expenses
- Medical bills
- Your children's education
- Daily expenses

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/life/needs**.

Employee Life Bi-Weekly Premiums

Coverage Amount	Employee's Age as of October 1											
	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75+*
$10,000	0.46	0.55	0.60	0.83	1.25	2.12	3.55	5.77	7.20	12.46	13.58	15.60
$20,000	0.92	1.11	1.20	1.66	2.49	4.25	7.11	11.54	14.40	24.92	27.15	31.20
$30,000	1.38	1.66	1.80	2.49	3.74	6.37	10.66	17.31	21.60	37.38	40.73	46.80
$40,000	1.85	2.22	2.40	3.32	4.98	8.49	14.22	23.08	28.80	49.85	54.30	62.40
$50,000	2.31	2.77	3.00	4.15	6.23	10.62	17.77	28.85	36.00	62.31	67.88	78.00
$60,000	2.77	3.32	3.60	4.98	7.48	12.74	21.32	34.62	43.20	74.77	81.45	93.60
$70,000	3.23	3.88	4.20	5.82	8.72	14.86	24.88	40.38	50.40	87.23	95.03	109.20
$80,000	3.69	4.43	4.80	6.65	9.97	16.98	28.43	46.15	57.60	99.69	108.60	124.80
$90,000	4.15	4.98	5.40	7.48	11.22	19.11	31.98	51.92	64.80	112.15	122.18	140.40
$100,000	4.62	5.54	6.00	8.31	12.46	21.23	35.54	57.69	72.00	124.62	135.75	156.00
$110,000	5.08	6.09	6.60	9.14	13.71	23.35	39.09	63.46	79.20	137.08	149.33	171.60
$120,000	5.54	6.65	7.20	9.97	14.95	25.48	42.65	69.23	86.40	149.54	162.90	187.20
$130,000	6.00	7.20	7.80	10.80	16.20	27.60	46.20	75.00	93.60	162.00	176.48	202.80
$140,000	6.46	7.75	8.40	11.63	17.45	29.72	49.75	80.77	100.80	174.46	190.05	218.40
$150,000	6.92	8.31	9.00	12.46	18.69	31.85	53.31	86.54	108.00	186.92	203.63	234.00
$160,000	7.38	8.86	9.60	13.29	19.94	33.97	56.86	92.31	115.20	199.38	217.20	249.60
$170,000	7.85	9.42	10.20	14.12	21.18	36.09	60.42	98.08	122.40	211.85	230.78	265.20
$180,000	8.31	9.97	10.80	14.95	22.43	38.22	63.97	103.85	129.60	224.31	244.35	280.80
$190,000	8.77	10.52	11.40	15.78	23.68	40.34	67.52	109.62	136.80	236.77	257.93	296.40
$200,000	9.23	11.08	12.00	16.62	24.92	42.46	71.08	115.38	144.00	249.23	271.50	312.00
$210,000	9.69	11.63	12.60	17.45	26.17	44.58	74.63	121.15	151.20	261.69	285.08	327.60
$220,000	10.15	12.18	13.20	18.28	27.42	46.71	78.18	126.92	158.40	274.15	298.66	343.20
$230,000	10.62	12.74	13.80	19.11	28.66	48.83	81.74	132.69	165.60	286.62	312.23	358.80
$240,000	11.08	13.29	14.40	19.94	29.91	50.95	85.29	138.46	172.80	299.08	325.81	374.40
$250,000	11.54	13.85	15.00	20.77	31.15	53.08	88.85	144.23	180.00	311.54	339.38	390.00
$260,000	12.00	14.40	15.60	21.60	32.40	55.20	92.40	150.00	187.20	324.00	352.96	405.60
$270,000	12.46	14.95	16.20	22.43	33.65	57.32	95.95	155.77	194.40	336.46	366.53	421.20
$280,000	12.92	15.51	16.80	23.26	34.89	59.45	99.51	161.54	201.60	348.92	380.11	436.80
$290,000	13.38	16.06	17.40	24.09	36.14	61.57	103.06	167.31	208.80	361.38	393.68	452.40
$300,000	13.85	16.62	18.00	24.92	37.38	63.69	106.62	173.08	216.00	373.85	407.26	468.00
$310,000	14.31	17.17	18.60	25.75	38.63	65.82	110.17	178.85	223.20	386.31	420.83	483.60
$320,000	14.77	17.72	19.20	26.58	39.88	67.94	113.72	184.62	230.40	398.77	434.41	499.20
$330,000	15.23	18.28	19.80	27.42	41.12	70.06	117.28	190.38	237.60	411.23	447.98	514.80
$340,000	15.69	18.83	20.40	28.25	42.37	72.18	120.83	196.15	244.80	423.69	461.56	530.40
$350,000	16.15	19.38	21.00	29.08	43.62	74.31	124.38	201.92	252.00	436.15	475.13	546.00
$360,000	16.62	19.94	21.60	29.91	44.86	76.43	127.94	207.69	259.20	448.62	488.71	561.60
$370,000	17.08	20.49	22.20	30.74	46.11	78.55	131.49	213.46	266.40	461.08	502.28	577.20
$380,000	17.54	21.05	22.80	31.57	47.35	80.68	135.05	219.23	273.60	473.54	515.86	592.80
$390,000	18.00	21.60	23.40	32.40	48.60	82.80	138.60	225.00	280.80	486.00	529.43	608.40
$400,000	18.46	22.15	24.00	33.23	49.85	84.92	142.15	230.77	288.00	498.46	543.01	624.00
$410,000	18.92	22.71	24.60	34.06	51.09	87.05	145.71	236.54	295.20	510.92	556.58	639.60
$420,000	19.38	23.26	25.20	34.89	52.34	89.17	149.26	242.31	302.40	523.38	570.16	655.20
$430,000	19.85	23.82	25.80	35.72	53.58	91.29	152.82	248.08	309.60	535.85	583.73	670.80
$440,000	20.31	24.37	26.40	36.55	54.83	93.42	156.37	253.85	316.80	548.31	597.31	686.40
$450,000	20.77	24.92	27.00	37.38	56.08	95.54	159.92	259.62	324.00	560.77	610.89	702.00
$460,000	21.23	25.48	27.60	38.22	57.32	97.66	163.48	265.38	331.20	573.23	624.46	717.60
$470,000	21.69	26.03	28.20	39.05	58.57	99.78	167.03	271.15	338.40	585.69	638.04	733.20
$480,000	22.15	26.58	28.80	39.88	59.82	101.91	170.58	276.92	345.60	598.15	651.61	748.80
$490,000	22.62	27.14	29.40	40.71	61.06	104.03	174.14	282.69	352.80	610.62	665.19	764.40
$500,000	23.08	27.69	30.00	41.54	62.31	106.15	177.69	288.46	360.00	623.08	678.76	780.00

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

How Much Your Coverage Costs

Your Basic Life insurance is paid for by City of Sunrise. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

Use this formula to calculate your premium payment:

_____	÷ 1000 =	_____	x	_____	=	_____	➡	_____
Enter the amount of coverage you are requesting (see benefit amounts in the About This Coverage section).				Enter your rate from the rate table.		This amount is an estimate of how much you would pay each month.		To get a sense of your biweekly premium, multiply your monthly premium amount by 12 and then divide by 26.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your spouse's age and your spouse's rate.

If you buy Dependents Life coverage for your child(ren), your monthly rate is $0.20 per $1,000, no matter how many children you're covering.

Age (as of October 1)	Your Rate (Per $1,000 of Total Coverage)	Your Spouse's Rate (Per $1,000 of Total Coverage)
<25	$0.10	$0.10
25-29	$0.12	$0.12
30–34	$0.13	$0.13
35–39	$0.18	$0.18
40–44	$0.27	$0.27
45–49	$0.46	$0.46
50–54	$0.77	$0.77
55–59	$1.25	$1.25
60–64	$1.56	$1.56
65–69	$2.70	$2.70
70–74	$4.39	$4.39
75+	$6.76	$6.76

Spouse Life Bi-Weekly Premiums

Coverage Amount	Spouse's Age as of October 1											
	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75+*
$5,000	0.23	0.28	0.30	0.42	0.62	1.06	1.78	2.88	3.60	6.23	6.79	7.80
$10,000	0.46	0.55	0.60	0.83	1.25	2.12	3.55	5.77	7.20	12.46	13.58	15.60
$15,000	0.69	0.83	0.90	1.25	1.87	3.18	5.33	8.65	10.80	18.69	20.36	23.40
$20,000	0.92	1.11	1.20	1.66	2.49	4.25	7.11	11.54	14.40	24.92	27.15	31.20
$25,000	1.15	1.38	1.50	2.08	3.12	5.31	8.88	14.42	18.00	31.15	33.94	39.00
$30,000	1.38	1.66	1.80	2.49	3.74	6.37	10.66	17.31	21.60	37.38	40.73	46.80
$35,000	1.62	1.94	2.10	2.91	4.36	7.43	12.44	20.19	25.20	43.62	47.51	54.60
$40,000	1.85	2.22	2.40	3.32	4.98	8.49	14.22	23.08	28.80	49.85	54.30	62.40
$45,000	2.08	2.49	2.70	3.74	5.61	9.55	15.99	25.96	32.40	56.08	61.09	70.20
$50,000	2.31	2.77	3.00	4.15	6.23	10.62	17.77	28.85	36.00	62.31	67.88	78.00
$55,000	2.54	3.05	3.30	4.57	6.85	11.68	19.55	31.73	39.60	68.54	74.66	85.80
$60,000	2.77	3.32	3.60	4.98	7.48	12.74	21.32	34.62	43.20	74.77	81.45	93.60
$65,000	3.00	3.60	3.90	5.40	8.10	13.80	23.10	37.50	46.80	81.00	88.24	101.40
$70,000	3.23	3.88	4.20	5.82	8.72	14.86	24.88	40.38	50.40	87.23	95.03	109.20
$75,000	3.46	4.15	4.50	6.23	9.35	15.92	26.65	43.27	54.00	93.46	101.81	117.00
$80,000	3.69	4.43	4.80	6.65	9.97	16.98	28.43	46.15	57.60	99.69	108.60	124.80
$85,000	3.92	4.71	5.10	7.06	10.59	18.05	30.21	49.04	61.20	105.92	115.39	132.60
$90,000	4.15	4.98	5.40	7.48	11.22	19.11	31.98	51.92	64.80	112.15	122.18	140.40
$95,000	4.38	5.26	5.70	7.89	11.84	20.17	33.76	54.81	68.40	118.38	128.96	148.20
$100,000	4.62	5.54	6.00	8.31	12.46	21.23	35.54	57.69	72.00	124.62	135.75	156.00
$105,000	4.85	5.82	6.30	8.72	13.08	22.29	37.32	60.58	75.60	130.85	142.54	163.80
$110,000	5.08	6.09	6.60	9.14	13.71	23.35	39.09	63.46	79.20	137.08	149.33	171.60
$115,000	5.31	6.37	6.90	9.55	14.33	24.42	40.87	66.35	82.80	143.31	156.12	179.40
$120,000	5.54	6.65	7.20	9.97	14.95	25.48	42.65	69.23	86.40	149.54	162.90	187.20
$125,000	5.77	6.92	7.50	10.38	15.58	26.54	44.42	72.12	90.00	155.77	169.69	195.00
$130,000	6.00	7.20	7.80	10.80	16.20	27.60	46.20	75.00	93.60	162.00	176.48	202.80
$135,000	6.23	7.48	8.10	11.22	16.82	28.66	47.98	77.88	97.20	168.23	183.27	210.60
$140,000	6.46	7.75	8.40	11.63	17.45	29.72	49.75	80.77	100.80	174.46	190.05	218.40
$145,000	6.69	8.03	8.70	12.05	18.07	30.78	51.53	83.65	104.40	180.69	196.84	226.20
$150,000	6.92	8.31	9.00	12.46	18.69	31.85	53.31	86.54	108.00	186.92	203.63	234.00
$155,000	7.15	8.58	9.30	12.88	19.32	32.91	55.08	89.42	111.60	193.15	210.42	241.80
$160,000	7.38	8.86	9.60	13.29	19.94	33.97	56.86	92.31	115.20	199.38	217.20	249.60
$165,000	7.62	9.14	9.90	13.71	20.56	35.03	58.64	95.19	118.80	205.62	223.99	257.40
$170,000	7.85	9.42	10.20	14.12	21.18	36.09	60.42	98.08	122.40	211.85	230.78	265.20
$175,000	8.08	9.69	10.50	14.54	21.81	37.15	62.19	100.96	126.00	218.08	237.57	273.00
$180,000	8.31	9.97	10.80	14.95	22.43	38.22	63.97	103.85	129.60	224.31	244.35	280.80
$185,000	8.54	10.25	11.10	15.37	23.05	39.28	65.75	106.73	133.20	230.54	251.14	288.60
$190,000	8.77	10.52	11.40	15.78	23.68	40.34	67.52	109.62	136.80	236.77	257.93	296.40
$195,000	9.00	10.80	11.70	16.20	24.30	41.40	69.30	112.50	140.40	243.00	264.72	304.20
$200,000	9.23	11.08	12.00	16.62	24.92	42.46	71.08	115.38	144.00	249.23	271.50	312.00
$205,000	9.46	11.35	12.30	17.03	25.55	43.52	72.85	118.27	147.60	255.46	278.29	319.80
$210,000	9.69	11.63	12.60	17.45	26.17	44.58	74.63	121.15	151.20	261.69	285.08	327.60
$215,000	9.92	11.91	12.90	17.86	26.79	45.65	76.41	124.04	154.80	267.92	291.87	335.40
$220,000	10.15	12.18	13.20	18.28	27.42	46.71	78.18	126.92	158.40	274.15	298.66	343.20
$225,000	10.38	12.46	13.50	18.69	28.04	47.77	79.96	129.81	162.00	280.38	305.44	351.00
$230,000	10.62	12.74	13.80	19.11	28.66	48.83	81.74	132.69	165.60	286.62	312.23	358.80
$235,000	10.85	13.02	14.10	19.52	29.28	49.89	83.52	135.58	169.20	292.85	319.02	366.60
$240,000	11.08	13.29	14.40	19.94	29.91	50.95	85.29	138.46	172.80	299.08	325.81	374.40
$245,000	11.31	13.57	14.70	20.35	30.53	52.02	87.07	141.35	176.40	305.31	332.59	382.20
$250,000	11.54	13.85	15.00	20.77	31.15	53.08	88.85	144.23	180.00	311.54	339.38	390.00

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Child Life Bi-Weekly Premiums

Coverage Amount	Premium
$2,500	0.23
$5,000	0.46
$7,500	0.69
$10,000	0.92

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Eligibility Requirements

To be eligible for basic and additional coverage, you must be:

- An active employee of City of Sunrise
- Regularly working at least 30 hours per week **OR:**
- An employee of City of Sunrise who retired under the Employer's retirement program
- Insured for Basic Life insurance through The Standard to qualify for Additional Life insurance

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

If you buy Additional Life insurance for yourself, you may also buy additional coverage for your eligible children and/or spouse. This is called Dependents Life insurance. You can choose to cover your spouse, meaning a person to whom you are legally married. Child means your child from live birth through age 25. Your child cannot be insured by more than one employee. Your spouse or child(ren) must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

Medical Underwriting Approval

Required for:

- Coverage amounts higher than the guarantee issue maximum amount
- All late applications (applying 31 days after becoming eligible)
- Requests for coverage increases
- Reinstatements
- Eligible but not insured under the prior life insurance plan

Visit **www.standard.com/mhs** to submit a medical history statement online.

Coverage Effective Date

To become insured, you must

- Meet the eligibility requirements listed in the previous sections,
- Serve an eligibility waiting period*,
- Receive medical underwriting approval (if applicable),
- Apply for coverage and agree to pay premium, and
- Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective.

If you are not actively at work on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee. Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your coverage.

*Defined as first of the month that follows or coincides with 30 consecutive days as a member

Life Insurance Age Reductions

Under this plan, your coverage amount reduces to 67 percent at age 70 and to 50 percent at age 75. Your spouse's coverage amount reduces by your spouse's age as follows: to 67 percent at age 70 and to 50 percent at age 75. If you or your spouse are age 70 or over, ask your human resources representative or plan administrator for the amount of coverage available.

Waiver of Premium

Your premiums may be waived if you:

- Become totally disabled while insured under this plan,
- Are under age 60, and
- Complete a waiting period of 180 days.

If these conditions are met, your Life insurance coverage may continue without cost until age 65, provided you give us satisfactory proof that you remain totally disabled.

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage from The Standard.

Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

Exclusions

Subject to state variations, you and your dependents are not covered for death resulting from suicide or other intentionally self-inflicted injury, while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy

In addition to the above requirements, your Dependents Life coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent.

For more details on when your insurance ends, contact your human resources representative or plan administrator.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP190-LIFE/S399, GP399-LIFE/TRUST, GP899-LIFE, GP190-LIFE/A997/S399, GP411-LIFE

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 12506-D-AL-FL-755780 (10/17)

Standard Insurance Company
City of Sunrise
Group Policy #755780

Group Accidental Death & Dismemberment Insurance

Enhance Your Safety Net With Protection Against Unexpected Loss

Accidental Death & Dismemberment (AD&D) insurance helps protect against the sudden financial loss often brought on by an accidental death. It can also help you pay for unexpected expenses associated with surviving an accident that results in a severe physical loss.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Coverage for accidental death and dismemberment

About This Coverage

How Much Can I Apply For?	For You:	**$10,000 – $500,000** in increments of **$10,000**

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Additional Features

Your coverage comes with some added features:

Seat Belt and Air Bag Benefits	The Standard may pay an additional benefit if you die while wearing a seat belt, provided certain conditions are met. If the car's air bags deploy during an accident, an air bag benefit may also be payable.
Family Benefits Package	This package is designed to help surviving family members maintain their standard of living and pursue their dreams. Included in the package are benefits to help with child care, career adjustment for your spouse and higher education for your children.
Line of Duty Benefit[1]	If you're a public safety officer, you may receive an additional $50,000 up to percent of your AD&D benefit if you suffer a loss as the result of a line of duty accident.

1 Public safety officers include police officers, firefighters, corrections officers, judicial officers and officially recognized or designated volunteer firefighters.

How Much Your Coverage Costs

Because this insurance is offered through City of Sunrise, you'll have access to competitive group rates. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on the benefit amount you elect.

Use this formula to calculate your premium payment:

_____ ÷ $1,000 = _____ x _____

Enter the amount of AD&D coverage you're requesting (see benefit amounts in the About This Coverage section).

Enter your rate from the rate table.

_____ → _____

This amount is an estimate of how much you would pay each month.

To get a sense of your biweekly premium, multiply your monthly premium amount by 12 and then divide by 26.

Coverage for...	Cost per $1,000 of Coverage
You	$0.03

Employee AD&D Bi-Weekly Premiums

Coverage Amount	Employee's Age as of October 1		
	< 70	70-74*	75+
$10,000	0.14	0.09	0.07
$20,000	0.28	0.19	0.14
$30,000	0.42	0.28	0.21
$40,000	0.55	0.37	0.28
$50,000	0.69	0.46	0.35
$60,000	0.83	0.56	0.42
$70,000	0.97	0.65	0.48
$80,000	1.11	0.74	0.55
$90,000	1.25	0.83	0.62
$100,000	1.38	0.93	0.69
$110,000	1.52	1.02	0.76
$120,000	1.66	1.11	0.83
$130,000	1.80	1.21	0.90
$140,000	1.94	1.30	0.97
$150,000	2.08	1.39	1.04
$160,000	2.22	1.48	1.11
$170,000	2.35	1.58	1.18
$180,000	2.49	1.67	1.25
$190,000	2.63	1.76	1.32
$200,000	2.77	1.86	1.38
$210,000	2.91	1.95	1.45
$220,000	3.05	2.04	1.52
$230,000	3.18	2.13	1.59
$240,000	3.32	2.23	1.66
$250,000	3.46	2.32	1.73
$260,000	3.60	2.41	1.80
$270,000	3.74	2.50	1.87
$280,000	3.88	2.60	1.94
$290,000	4.02	2.69	2.01
$300,000	4.15	2.78	2.08
$310,000	4.29	2.88	2.15
$320,000	4.43	2.97	2.22
$330,000	4.57	3.06	2.28
$340,000	4.71	3.15	2.35
$350,000	4.85	3.25	2.42
$360,000	4.98	3.34	2.49
$370,000	5.12	3.43	2.56
$380,000	5.26	3.53	2.63
$390,000	5.40	3.62	2.70
$400,000	5.54	3.71	2.77
$410,000	5.68	3.80	2.84
$420,000	5.82	3.90	2.91
$430,000	5.95	3.99	2.98
$440,000	6.09	4.08	3.05
$450,000	6.23	4.17	3.12
$460,000	6.37	4.27	3.18
$470,000	6.51	4.36	3.25
$480,000	6.65	4.45	3.32
$490,000	6.78	4.55	3.39
$500,000	6.92	4.64	3.46

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Eligibility Requirements

To be eligible for coverage, you must be:

- An active employee of City of Sunrise
- Regularly working at least 30 hours per week **OR;**
- An employee of City of Sunrise who retired under the Employer's retirement program

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

Coverage Effective Date

To become insured, you must

- Meet the eligibility requirements listed in the previous sections,
- Serve an eligibility waiting period*,
- Apply for coverage and agree to pay premium and
- Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your coverage.

*Defined as first of the month that follows or coincides with 30 consecutive days as a member

Age Reductions

Under this plan, your coverage amount reduces to 67 percent at age 70 and to 50 percent at age 75. If you are age 70 or over, ask your human resources representative or plan administrator for the amount of coverage available.

AD&D Benefits

The amount of your AD&D benefit for losses covered under this plan is a percentage of the amount of your AD&D insurance in effect on the date of the covered accident as shown below. No more than 100 percent of the AD&D benefit will be paid for all losses resulting from one accident.

Any loss must be caused solely and directly by an accident within 365 days of the accident. A certified copy of the death certificate is needed to prove loss of life.

Covered loss:	Percentage of AD&D benefit payable:
Life[1]	100%
One hand or one foot[2]	50%
Sight in one eye, speech or hearing in both ears	50%
Two or more of the losses listed above	100%
Thumb and index finger of the same hand[3]	25%

All other losses must be certified by a physician in the appropriate specialty determined by The Standard.

1 Includes loss of life caused by accidental exposure to adverse weather conditions or disappearance if disappearance is caused by an accident that reasonably could have resulted in your death.

2 Even if the severed part is surgically re-attached.

3 This benefit is not payable if an AD&D benefit is payable for the loss of the entire hand.

Exclusions

You are not covered for death or dismemberment caused or contributed to by any of the following:

- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Suicide or other intentionally self-inflicted injury, while sane or insane
- War or act of war (declared or undeclared), whether civil or international, and any substantial armed conflict between organized forces of a military nature
- Voluntary consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above
- Boarding, leaving or being in or on any kind of aircraft, unless you are a fare-paying passenger on a commercial aircraft

When Your Insurance Ends

Coverage ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements

(insurance may continue for limited periods under certain circumstances)

- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy

For more details on when your insurance ends, contact your human resources representative or plan administrator.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP494-ADD/S399, GP310-ADD, GP609-ADD

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 15455-D-FL-755780 (10/17)

CITY OF SUNRISE
VOLUNTARY TERM LIFE & ACCIDENT INSURANCE
DEDUCTION FORM

		Effective Date
Employee Name (Last, First, MI)	Social Security Number(last 4 digits)	Department
☐ Enrollment ☐ Change Coverage ☐ Discontinue Coverage ☐ Correction	** THIS BENEFIT IS NOT ELIGIBLE AS A PRE-TAX DEDUCTION** Deduction Code	

PLAN	Volume	Bi Weekly Deduction
Voluntary Employee Basic	$	$
Voluntary Employee AD&D		
Voluntary Spouse		
Voluntary Child		
Total Bi-Weekly Deduction:		**$**

REMARKS:

Employee Signature

Date

Risk Approval

Date

Date Mailed to Payroll
(Risk Use Only)

HTE Entered Date
(Payroll Use Only)

Rev 1/2016

Reset

Standard Insurance Company **Beneficiary Designation/Change**

This designation will apply to the following Standard Insurance Company coverage(s) if available to you through your Employer: Life Insurance, Life with Accidental Death & Dismemberment (AD&D) Insurance, AD&D Insurance and, unless specified otherwise on a separate signed sheet of paper, Supplemental Life Insurance.

Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to your Employer during your lifetime. Return the completed form to your Risk Management Department.

MEMBER/EMPLOYEE INFORMATION

Your Name (Last, First, Middle)		Date of Birth
Your Address		
City	State	Zip
Group Name **City of Sunrise**	Group No. **755780**	

BENEFICIARY INFORMATION

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe, 60%; Jane Q. Doe, 40%.

PRIMARY - Full Name	Address	Date of Birth	Relationship	% of Benefit

CONTINGENT - Full Name	Address	Date of Birth	Relationship	% of Benefit

Signature of Member/Employee

Date

Risk Management Department - *Retain for your records.*

Print (12/09)

Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

Medical History Statement
For Residents of: Florida

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 3. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 2. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

MEMBER/EMPLOYEE INFORMATION

Name of Group		Group Number	Check who is Applying (One per form)
City of Sunrise		**755780**	☐ Member/Employee ☐ Spouse ☐ Child
Member/Employee Name		Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)
Occupation	Salary	Social Security Number	Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)			Email Address	
Street Address	City	State Zip		Residency ☐ USA ☐ Other
Sex ☐M ☐F	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

APPLICATION INFORMATION

Type of Application *(check one)* ☐ Initial ☐ Increase in Coverage ☐ Late Application

Check the type and provide details on the amount of coverage you are requesting.

☐ Short Term Disability

☐ Long Term Disability _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

☐ Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

☐ Dependents Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

NOTE: Medical questions do not relate to Disability products for amounts over the Guaranteed Issue.

1. Are you now unable to maintain full time employment as defined by a licensed medical professional because of any physical or mental condition, or injury? ☐ Yes ☐ No
2. Has a licensed member of the medical profession ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or any disease of the digestive system? ☐ Yes ☐ No
   - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? ☐ Yes ☐ No
   - C. Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? ☐ Yes ☐ No
   - D. Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disease? ☐ Yes ☐ No
   - E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? ☐ Yes ☐ No
   - F. Lupus, scleroderma, vasculitis, connective tissue disease, or an immune system disorder not related to Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   - G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions? ☐ Yes ☐ No
   - H. Diabetes, thyroid, gland, spleen, or nephritis? ☐ Yes ☐ No
   - I. Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? ☐ Yes ☐ No
   - J. Psychiatric or mental condition, depression, Adjustment Disorder (AD), Generalized Anxiety Disorder (GAD), or Obsessive Compulsive Disorder (OCD)? ☐ Yes ☐ No
3. In the past 7 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or visits to a licensed member of the medical profession? ☐ Yes ☐ No
4. Have you tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No
5. Have you been advised by a licensed medical professional to have any operation or to schedule an appointment for an existing physical or mental condition, or injury? ☐ Yes ☐ No
6. Have you been diagnosed by a licensed medical professional as currently being pregnant? ☐ Yes ☐ No

Height	Weight	Physician Name or Medical Facility with Applicant's Complete Medical Records (provide name and full mailing address)

Applicant Name	Social Security Number

Describe any "yes" answers below. (Please provide the entire question number.)

Question Number	*Description of Injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION *(Please read carefully.)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.

FRAUD NOTICE

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Applicant (or Member/Employee for Dependent Child)	**Date**

Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.

Applicant Name	Social Security Number

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

  Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

  Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

AFLAC INSURANCE

Mario Zingales, Benefits Advisor Professional
AFLAC - Florida Southeast
Office (954) 474-4108
Fax (954) 474-4305
Mobile (954) 303-1056
director@thezro.com or Mario@fsgsfl.com

Aflac

Cancer Protection Assurance

CANCER INDEMNITY INSURANCE – OPTION 1

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

Mario Zingales
Benefits Advisor Professional
AFLAC - Florida Southeast
Office (954) 474-4108
Fax (954) 474-4305
Mobile (954) 303-1056
director@thezro.com
Mario@fsgsfl.com

The policy is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

Aflac SmartClaim®
One Day Pay™

B70175FL

IC(10/18)

Coverage Options

Choose the Policy and Riders that Fit Your Needs

BENEFIT	DESCRIPTION
CANCER SCREENING	One $25 benefit per calendar year, per covered person Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition
PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT)	$125 per covered person, per lifetime
INITIAL DIAGNOSIS	Named Insured or Spouse: $1,000 Dependent Child: $2,000 Payable once per covered person, per lifetime
ADDITIONAL OPINION	$150 per covered person, per lifetime
RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY	Self-Administered: $100 per calendar month Physician Administered: $600 per calendar month This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month.
HORMONAL THERAPY	$15 once per calendar month
TOPICAL CHEMOTHERAPY	$100 once per calendar month
ANTINAUSEA	$50 once per calendar month
STEM CELL AND BONE MARROW TRANSPLANTATION	$3,500; lifetime maximum of $3,500 per covered person Donor Benefit: $50 for stem cell donation, or $500 for bone marrow donation Payable one time per covered person
BLOOD AND PLASMA	Inpatient: $50 times the number of days paid under the Hospital Confinement Benefit, per covered person Outpatient: $140 per day, per covered person
SURGERY/ANESTHESIA	$50-$1,700 Anesthesia: additional 25% of the Surgery Benefit Maximum daily benefit will not exceed $2,125; no lifetime maximum on the number of operations
SKIN CANCER SURGERY	Laser or Cryosurgery: $20 Excision of lesion of skin without flap or graft: $85 Flap or graft without excision: $125 Excision of lesion of skin with flap or graft: $200 Maximum daily benefit will not exceed $200. No lifetime maximum on the number of operations
PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS)	$125 per covered person, per lifetime
HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS	Named Insured or Spouse: $100 Dependent Child: $125
HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE	Named Insured or Spouse: $200 Dependent Child: $250
OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE	$100 per day, per covered person

EXTENDED-CARE FACILITY	$75 per day; limited to 30 days in each calendar year, per covered person
HOME HEALTH CARE	$50 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person
HOSPICE CARE	$1,000 for first day; $50 per day thereafter; $12,000 lifetime maximum per covered person
NURSING SERVICES	$50 per day; payable for only the number of days the Hospital Confinement Benefit is payable
SURGICAL PROSTHESIS	$1,000; lifetime maximum of $2,000 per covered person
NONSURGICAL PROSTHESIS	$90 per occurrence, per covered person; lifetime maximum of $180 per covered person
BREAST RECONSTRUCTION	Breast Tissue/Muscle Reconstruction Flap Procedures: $1,000 Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): $250 Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): $110 Permanent Areola Repigmentation (on the diseased breast): $50 Maximum daily benefit will not exceed $1,000
OTHER RECONSTRUCTIVE SURGERY	Facial Reconstruction: $250 Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit Maximum daily benefit will not exceed $250
EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION	$500 for a covered person to have oocytes extracted and harvested $100 for the storage of a covered person's oocyte(s) or sperm $100 for embryo transfer Lifetime maximum of $700 per covered person
ANNUAL CARE	$100 on the anniversary date of diagnosis; lifetime maximum of five annual $100 payments per covered person
AMBULANCE	$250 ground $2,000 air ambulance
TRANSPORTATION	$.35 cents per mile for transportation; payable up to a combined maximum of $1,050, per round trip
LODGING	$50 per day; limited to 90 days per calendar year
WAIVER OF PREMIUM	Yes

OPTIONAL RIDERS	DESCRIPTION
INITIAL DIAGNOSIS BUILDING BENEFIT RIDER	This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force.
SPECIFIED-DISEASE BENEFIT RIDER	When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:

Initial diagnosis	Hospitalization	
$2,000	30 days or less: $400 per day	31 days or more: $800 per day

DEPENDENT CHILD RIDER	$10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child

Aflac

Cancer Protection Assurance

CANCER INDEMNITY INSURANCE – OPTION 2

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

The policy is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

Aflac SmartClaim®
One Day Pay™

Coverage Options

Choose the Policy and Riders that Fit Your Needs

BENEFIT	DESCRIPTION
CANCER SCREENING	One $75 benefit per calendar year, per covered person Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition
PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT)	$250 per covered person, per lifetime
INITIAL DIAGNOSIS	Named Insured or Spouse: $4,000 Dependent Child: $8,000 Payable once per covered person, per lifetime
ADDITIONAL OPINION	$300 per covered person, per lifetime
RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY	Self-Administered: $250 per calendar month Physician Administered: $1,200 per calendar month This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month.
HORMONAL THERAPY	$25 once per calendar month
TOPICAL CHEMOTHERAPY	$150 once per calendar month
ANTINAUSEA	$100 once per calendar month
STEM CELL AND BONE MARROW TRANSPLANTATION	$7,000: lifetime maximum of $7,000 per covered person Donor Benefit: $100 for stem cell donation, or $750 for bone marrow donation Payable one time per covered person
BLOOD AND PLASMA	Inpatient: $50 times the number of days paid under the Hospital Confinement Benefit, per covered person Outpatient: $175 per day, per covered person
SURGERY/ANESTHESIA	$100-$3,400 Anesthesia: additional 25% of the Surgery Benefit Maximum daily benefit will not exceed $4,250; no lifetime maximum on the number of operations
SKIN CANCER SURGERY	Laser or Cryosurgery: $35 Excision of lesion of skin without flap or graft: $170 Flap or graft without excision: $250 Excision of lesion of skin with flap or graft: $400 Maximum daily benefit will not exceed $400. No lifetime maximum on the number of operations
PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS)	$250 per covered person, per lifetime
HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS	Named Insured or Spouse: $200 Dependent Child: $250
HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE	Named Insured or Spouse: $400 Dependent Child: $500
OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE	$200 per day, per covered person

EXTENDED-CARE FACILITY	$100 per day; limited to 30 days in each calendar year, per covered person
HOME HEALTH CARE	$100 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person
HOSPICE CARE	$1,000 for first day; $50 per day thereafter; $12,000 lifetime maximum per covered person
NURSING SERVICES	$100 per day; payable for only the number of days the Hospital Confinement Benefit is payable
SURGICAL PROSTHESIS	$2,000; lifetime maximum of $4,000 per covered person
NONSURGICAL PROSTHESIS	$175 per occurrence, per covered person; lifetime maximum of $350 per covered person
BREAST RECONSTRUCTION	Breast Tissue/Muscle Reconstruction Flap Procedures: $2,000 Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): $500 Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): $220 Permanent Areola Repigmentation (on the diseased breast): $100 Maximum daily benefit will not exceed $2,000
OTHER RECONSTRUCTIVE SURGERY	Facial Reconstruction: $500 Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit Maximum daily benefit will not exceed $500
EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION	$1,000 for a covered person to have oocytes extracted and harvested $200 for the storage of a covered person's oocyte(s) or sperm $200 for embryo transfer Lifetime maximum of $1,400 per covered person
ANNUAL CARE	$200 on the anniversary date of diagnosis; lifetime maximum of five annual $200 payments per covered person
AMBULANCE	$250 ground $2,000 air ambulance
TRANSPORTATION	$.40 cents per mile for transportation; payable up to a combined maximum of $1,200, per round trip
LODGING	$65 per day; limited to 90 days per calendar year
WAIVER OF PREMIUM	Yes

OPTIONAL RIDERS	DESCRIPTION
INITIAL DIAGNOSIS BUILDING BENEFIT RIDER	This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force.
SPECIFIED-DISEASE BENEFIT RIDER	When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:

Initial diagnosis	Hospitalization	
$2,000	30 days or less: $400 per day	31 days or more: $800 per day

DEPENDENT CHILD RIDER	$10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child

Aflac Accident Advantage

ACCIDENT-ONLY INSURANCE – OPTION 2

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

Aflac SmartClaim®
One Day Pay℠

AFLAC ACCIDENT ADVANTAGE

BENEFIT NAME	BENEFIT AMOUNT
INITIAL ACCIDENT HOSPITALIZATION BENEFIT	$1,000 when admitted for a hospital confinement of at least 18 hours or $1,500 when admitted directly to an intensive care unit of a hospital for a covered accident, per calendar year, per covered person
ACCIDENT HOSPITAL CONFINEMENT BENEFIT	$200 per day, up to 365 days per covered accident, per covered person
INTENSIVE CARE UNIT CONFINEMENT BENEFIT	Additional $400 per day for up to 15 days, per covered accident, per covered person
ACCIDENT TREATMENT BENEFIT	Payable once per 24-hour period and only once per covered accident, per covered person Hospital emergency room with X-ray: $200 Hospital emergency room without X-ray: $170 Office or facility (other than a hospital emergency room) with X-ray: $150 Office or facility (other than a hospital emergency room) without X-ray: $120
AMBULANCE BENEFIT	$150 ground ambulance transportation or $1,000 air ambulance transportation
BLOOD/PLASMA/PLATELETS BENEFIT	$100 once per covered accident, per covered person
MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT	$150 per calendar year, per covered person
ACCIDENT FOLLOW-UP TREATMENT BENEFIT	$25 for one treatment per day (up to a max of 6 treatments), per covered accident, per covered person
THERAPY BENEFIT	$25 for one treatment per day (up to a max of 10 treatments), per covered accident, per covered person
APPLIANCES BENEFIT	Benefits are payable for the medical appliances listed below: Back brace: $250 — Wheelchair: $250 — Walker: $50 Body jacket: $250 — Leg brace: $75 — Walking boot: $50 Knee scooter: $250 — Crutches: $50 — Cane: $25 Payable once per covered accident, per covered person
PROSTHESIS BENEFIT	$500 once per covered accident, per covered person
PROSTHESIS REPAIR OR REPLACEMENT BENEFIT	$500 once per covered person, per lifetime
REHABILITATION FACILITY BENEFIT	$100 per day
HOME MODIFICATION BENEFIT	$2,000 once per covered accident, per covered person
ACCIDENT SPECIFIC-SUM INJURIES BENEFITS	Pays benefits for the treatments listed below:

DISLOCATIONS ..... $75–$3,000
BURNS ..... $100–$10,000
SKIN GRAFTS ..... 50% of the burns benefit amount paid for the burn involved
EYE INJURIES
Surgical repair $250
Removal of foreign body by a physician .. $50
LACERATIONS
Not requiring sutures $25
Less than 5 centimeters $50
At least 5 cm but not more than 15 cm . $200
Over 15 centimeters $400
FRACTURES ..... $100–$2,750
CONCUSSION (brain) $100

EMERGENCY DENTAL WORK
Broken tooth repaired with crown $300
Broken tooth resulting in extraction $100
COMA $10,000
PARALYSIS
Quadriplegia $10,000
Paraplegia $5,000
Hemiplegia $4,000
SURGICAL PROCEDURES ..... $175–$1,000
MISCELLANEOUS SURGICAL PROCEDURES ..... $100–$250
PAIN MANAGEMENT (NON-SURGICAL)
Epidural $100

ACCIDENTAL-DEATH BENEFIT

	Common-Carrier Accident	Other Accident	Hazardous Activity Accident
INSURED	$125,000	$31,500	$10,000
SPOUSE	$125,000	$31,500	$10,000
CHILD	$18,750	$10,000	$5,000

ACCIDENTAL-DISMEMBERMENT BENEFIT	$250–$25,000
WELLNESS BENEFIT	$60 once per calendar year
FAMILY SUPPORT BENEFIT	$20 per day (up to 30 days), per covered accident
ORGANIZED SPORTING ACTIVITY BENEFIT	Additional 25% of the benefits payable, limited to $1,000 per policy, per calendar year
WAIVER OF PREMIUM BENEFIT	Yes
TRANSPORTATION BENEFIT	$400 per round trip, up to 3 round trips per calendar year, per covered person
FAMILY LODGING BENEFIT	$100 per night, up to 30 days per covered accident

REFER TO THE OUTLINE OF COVERAGE AND POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

Aflac Accident Advantage

ACCIDENT-ONLY INSURANCE – OPTION 3

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

Aflac SmartClaim®
One Day Pay℠

AFLAC ACCIDENT ADVANTAGE

BENEFIT NAME	BENEFIT AMOUNT
INITIAL ACCIDENT HOSPITALIZATION BENEFIT	$1,000 when admitted for a hospital confinement of at least 18 hours or $2,000 when admitted directly to an intensive care unit of a hospital for a covered accident, per calendar year, per covered person
ACCIDENT HOSPITAL CONFINEMENT BENEFIT	$250 per day, up to 365 days per covered accident, per covered person
INTENSIVE CARE UNIT CONFINEMENT BENEFIT	Additional $400 per day for up to 15 days, per covered accident, per covered person
ACCIDENT TREATMENT BENEFIT	Payable once per 24-hour period and only once per covered accident, per covered person Hospital emergency room with X-ray: $200 Hospital emergency room without X-ray: $170 Office or facility (other than a hospital emergency room) with X-ray: $150 Office or facility (other than a hospital emergency room) without X-ray: $120
AMBULANCE BENEFIT	$200 ground ambulance transportation or $1,500 air ambulance transportation
BLOOD/PLASMA/PLATELETS BENEFIT	$200 once per covered accident, per covered person
MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT	$200 per calendar year, per covered person
ACCIDENT FOLLOW-UP TREATMENT BENEFIT	$35 for one treatment per day (up to a max of 6 treatments), per covered accident, per covered person
THERAPY BENEFIT	$35 for one treatment per day (up to a max of 10 treatments), per covered accident, per covered person
APPLIANCES BENEFIT	Benefits are payable for the medical appliances listed below: Back brace: $300 — Wheelchair: $300 — Walker: $100 Body jacket: $300 — Leg brace: $125 — Walking boot: $100 Knee scooter: $300 — Crutches: $100 — Cane: $25 Payable once per covered accident, per covered person
PROSTHESIS BENEFIT	$800 once per covered accident, per covered person
PROSTHESIS REPAIR OR REPLACEMENT BENEFIT	$800 once per covered person, per lifetime
REHABILITATION FACILITY BENEFIT	$150 per day
HOME MODIFICATION BENEFIT	$3,000 once per covered accident, per covered person
ACCIDENT SPECIFIC-SUM INJURIES BENEFITS	Pays benefits for the treatments listed below: DISLOCATIONS ..... $100–$3,750 BURNS ..... $125–$12,500 SKIN GRAFTS ..... 50% of the burns benefit amount paid for the burn involved EYE INJURIES Surgical repair ..... $300 Removal of foreign body by a physician .. $65 LACERATIONS Not requiring sutures ..... $35 Less than 5 centimeters ..... $65 At least 5 cm but not more than 15 cm . $250 Over 15 centimeters ..... $500 FRACTURES ..... $125–$3,500 CONCUSSION (brain) ..... $150 EMERGENCY DENTAL WORK Broken tooth repaired with crown ..... $400 Broken tooth resulting in extraction ..... $130 COMA ..... $12,500 PARALYSIS Quadriplegia ..... $12,500 Paraplegia ..... $6,250 Hemiplegia ..... $4,750 SURGICAL PROCEDURES ..... $200–$1,250 MISCELLANEOUS SURGICAL PROCEDURES ..... $120–$300 PAIN MANAGEMENT (NON-SURGICAL) Epidural $100

ACCIDENTAL-DEATH BENEFIT

	Common-Carrier Accident	Other Accident	Hazardous Activity Accident
INSURED	$187,500	$50,000	$10,000
SPOUSE	$187,500	$50,000	$10,000
CHILD	$31,250	$15,500	$5,000

ACCIDENTAL-DISMEMBERMENT BENEFIT	$300–$40,000
WELLNESS BENEFIT	$60 once per calendar year
FAMILY SUPPORT BENEFIT	$20 per day (up to 30 days), per covered accident
ORGANIZED SPORTING ACTIVITY BENEFIT	Additional 25% of the benefits payable, limited to $1,000 per policy, per calendar year
WAIVER OF PREMIUM BENEFIT	Yes
TRANSPORTATION BENEFIT	$600 per round trip, up to 3 round trips per calendar year, per covered person
FAMILY LODGING BENEFIT	$125 per night, up to 30 days per covered accident

REFER TO THE OUTLINE OF COVERAGE AND POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

Aflac Critical Care Protection

SPECIFIED HEALTH EVENT INSURANCE – OPTION 1

We've been dedicated to helping provide peace of mind and financial security for over 60 years.

Aflac®

Aflac Critical Care Protection – Option 1 Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
FIRST-OCCURRENCE BENEFIT:	
Named Insured/Spouse	$7,500; lifetime maximum $7,500 per covered person
Dependent Children	$10,000; lifetime maximum $10,000 per covered person
SUBSEQUENT SPECIFIED HEALTH EVENT BENEFIT	$3,500 Subsequent occurrence limitations apply. No lifetime maximum.
CORONARY ANGIOPLASTY BENEFIT	$1,000 Payable only once per covered person, per lifetime
HOSPITAL CONFINEMENT BENEFIT	$300 per day No lifetime maximum
AMBULANCE BENEFIT	$250 ground or $2,000 air No lifetime maximum
CONTINUING CARE BENEFIT	$125 each day when a covered person is charged for any of the following treatments: • Rehabilitation Therapy • Physical Therapy • Speech Therapy • Occupational Therapy • Respiratory Therapy • Dietary Therapy/Consultation • Home Health Care • Dialysis • Hospice Care • Extended Care • Physician Visits • Nursing Home Care Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered loss. No lifetime maximum.
TRANSPORTATION BENEFIT	$.50 per mile, per covered person whom special treatment is prescribed, for a covered loss Limited to $1,500 per occurrence; no lifetime maximum
LODGING BENEFIT	Up to $75 per day, for covered lodging charges Limited to 15 days per occurrence; no lifetime maximum
WAIVER OF PREMIUM BENEFIT	Premium waived, from month to month, during total inability (after 180 continuous days)

REFER TO THE FOLLOWING OUTLINE OF COVERAGE FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

Aflac Critical Care Protection

SPECIFIED HEALTH EVENT INSURANCE – OPTION 2

We've been dedicated to helping provide peace of mind and financial security for over 60 years.

Aflac

Aflac Critical Care Protection – Option 2 Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
HOSPITAL INTENSIVE CARE UNIT BENEFIT	Days 1–7: $800 per day Days 8–15: $1,300 per day Limited to 15 days per period of confinement; no lifetime maximum
STEP-DOWN INTENSIVE CARE UNIT BENEFIT	$500 per day Limited to 15 days per period of confinement; no lifetime maximum
PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP-DOWN INTENSIVE CARE UNIT CONFINEMENT	An indemnity of $2 will accumulate for the named insured and the covered spouse for each calendar month the policy remains in force after the effective date
FIRST-OCCURRENCE BENEFIT:	
Named Insured/Spouse	$7,500; lifetime maximum $7,500 per covered person
Dependent Children	$10,000; lifetime maximum $10,000 per covered person
SUBSEQUENT SPECIFIED HEALTH EVENT BENEFI	$3,500 Subsequent occurrence limitations apply. No lifetime maximum.
CORONARY ANGIOPLASTY BENEFIT	$1,000 Payable only once per covered person, per lifetime
HOSPITAL CONFINEMENT BENEFIT	$300 per day No lifetime maximum
CONTINUING CARE BENEFIT	$125 each day when a covered person is charged for any of the following treatments: • Rehabilitation Therapy • Physical Therapy • Speech Therapy • Occupational Therapy • Respiratory Therapy • Dietary Therapy/Consultation • Home Health Care • Dialysis • Hospice Care • Extended Care • Physician Visits • Nursing Home Care Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered specified health event or coronary angioplasty. No lifetime maximum.
AMBULANCE BENEFIT	$250 ground or $2,000 air No lifetime maximum
TRANSPORTATION BENEFIT	$.50 per mile, per covered person whom special treatment is prescribed, for a covered loss Limited to $1,500 per occurrence; no lifetime maximum
LODGING BENEFIT	Up to $75 per day, for covered lodging charges Limited to 15 days per occurrence; no lifetime maximum
WAIVER OF PREMIUM BENEFIT	Premium waived, from month to month, during total inability (after 180 continuous days)

REFER TO THE FOLLOWING OUTLINE OF COVERAGE FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

OPTIONAL FIRST-OCCURRENCE BUILDING BENEFIT

RIDER SUMMARY PAGE

Policy Rider Series A74000

CCP®

PEACE OF MIND. CASH BENEFITS.

OUR INSURANCE POLICIES HELP PROVIDE BOTH.

The First-Occurrence Building Benefit Rider is a part of the policy and is subject to all policy provisions, unless modified herein.

WHAT WE WILL PAY

FIRST-OCCURRENCE BENEFIT

The First-Occurrence Benefit will be increased by $500 on each rider anniversary date while the rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of the rider following the covered person's 65th birthday or at the time of a specified health event, subject to the Limitations and Exclusions of the policy, for that covered person, whichever occurs first. However, regardless of the age of the covered person on the effective date of the rider, this benefit will accrue for a period of at least five years unless a specified health event is diagnosed prior to the fifth year of coverage.

DEFINITIONS

EFFECTIVE DATE

The effective date of the rider is as stated in the Policy Schedule.

TERMINATION

The rider will terminate if the policy to which it is attached terminates, when the benefit has been paid to all covered persons as described in the First-Occurrence Benefit listed in your policy, or if the premium for the rider is not paid, or our receipt of your written request to cancel the rider, subject to section 125 of the Internal Revenue Code, if applicable.

REFER TO THE POLICY AND RIDER FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS, AND EXCLUSIONS.

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999
aflac.com | 1.800.99.AFLAC (1.800.992.3522)

Aflac

Aflac
Short-Term Disability Insurance

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.

Aflac®

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with expenses incurred due to medical treatment, ongoing living expenses or any purpose you choose.

Coverage Options

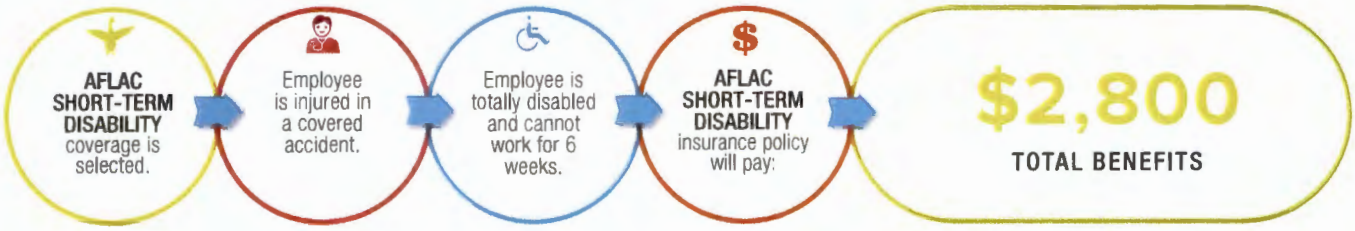
Choose the Policy You Need

BENEFIT	DESCRIPTION
MONTHLY BENEFIT PAYMENT	$500 to $6,000 (subject to income requirements)
TOTAL DISABILITY BENEFIT PERIODS	3, 6, 12, 18 or 24 months
ELIMINATION PERIODS (INJURY/SICKNESS)	0/7, 0/14, 7/7, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90, 180/180
WAIVER OF PREMIUM	Premium waived, month to month, for policy and any applicable rider(s) for as long as you remain disabled, up to the applicable benefit period shown in the Policy Schedule. Not available with a 3-month total disability benefit period.
OPTIONAL RIDERS	
DISABILITY BENEFIT FOR ON-THE-JOB INJURY RIDER	Provides benefits if a disability is caused by a covered on-the-job injury while coverage is in force. Available even with Workers' Compensation.* Benefits payable up to the total disability benefit period selected. Benefit subject to elimination period shown in the Policy Schedule and income requirements.
ADDITIONAL UNITS OF DISABILITY BENEFIT RIDER	Allows you to purchase additional units of disability coverage to add to your existing short-term disability policy. Subject to income requirements.

All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations and other policy terms.

*Subject to certain conditions/maximum.

How it works



The above example is based on a scenario for Aflac Short-Term Disability that includes the following benefit conditions: ages 18–49, employed full-time at the time disability began, $2,000 monthly disability benefit amount, $40,000 annual salary, elimination period 0/7 days, 3 month benefit period, benefits based on policy premiums being paid with after-tax dollars.

The policy has limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer.
This brochure is for illustrative purposes only. Refer to the outline of coverage and policy for complete benefit details, definitions. limitations, and exclusions.

City of Sunrise

Florida Payroll Premium rates are Biweekly for industry Class A.

The rates shown on this insert page are for illustration purposes only; they do not imply coverage. For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

AFLAC-SHORT TERM DISABILITY - Series A-57600

Elimination Period Accident/Sickness - 0/14 DAYS

Annual Income		$43,000	$45,000	$47,000	$49,000	$50,000	$52,000	$55,000	$57,000	$58,000	$60,000
Benefit Period	**Age**	**$2,200**	**$2,300**	**$2,400**	**$2,500**	**$2,600**	**$2,700**	**$2,800**	**$2,900**	**$3,000**	**$3,100**
6 MONTHS	18-49	$18.48	$19.32	$20.16	$21.00	$21.84	$22.68	$23.52	$24.36	$25.20	$26.04
	50-64	$22.44	$23.46	$24.48	$25.50	$26.52	$27.54	$28.56	$29.58	$30.60	$31.62
	65-74	$27.72	$28.98	$30.24	$31.50	$32.76	$34.02	$35.28	$36.54	$37.80	$39.06

Accident Advantage - 24-HOUR ACCIDENT OPTION 2 - Series A36000

		Premium	Total
18-75	INDIVIDUAL	$6.54	$6.54
18-75	NAMED INSURED/SPOUSE	$10.38	$10.38
18-75	ONE-PARENT FAMILY	$12.78	$12.78
18-75	TWO-PARENT FAMILY	$17.22	$17.22

Accident Advantage - 24-HOUR ACCIDENT OPTION 3 - Series A36000

		Premium	Total
18-75	INDIVIDUAL	$8.58	$8.58
18-75	NAMED INSURED/SPOUSE	$14.04	$14.04
18-75	ONE-PARENT FAMILY	$15.30	$15.30
18-75	TWO-PARENT FAMILY	$21.60	$21.60

Mario Zingales
Office:954-474-4108/Fax:954-474-4305
support@fsgsfl.com

City of Sunrise

Florida Payroll Premium rates are Biweekly for industry Class A.

The rates shown on this insert page are for illustration purposes only; they do not imply coverage. For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

CANCER PROTECTION ASSURANCE PLAN LEVEL 1 - Series B70100

		Premium	SDR*	Total
18-75	INDIVIDUAL	$8.35	$0.42	$8.77
18-75	INSURED/SPOUSE	$13.40	$0.42	$13.82
18-75	ONE-PARENT FAMILY	$8.35	$0.42	$8.77
18-75	TWO-PARENT FAMILY	$13.40	$0.42	$13.82

SDR = Optional Specified Disease Rider (Series B70052) premium*

CANCER PROTECTION ASSURANCE PLAN LEVEL 2 - Series B70200

		Premium	SDR*	Total
18-75	INDIVIDUAL	$17.58	$0.42	$18.00
18-75	INSURED/SPOUSE	$30.40	$0.42	$30.82
18-75	ONE-PARENT FAMILY	$17.58	$0.42	$18.00
18-75	TWO-PARENT FAMILY	$30.40	$0.42	$30.82

SDR = Optional Specified Disease Rider (Series B70052) premium*

CRITICAL CARE PROTECTION POLICY - Series A74100

Individual

Age	Premium	FOBBR	Total
18-35	$4.08	$1.02	$5.10
36-45	$6.36	$1.86	$8.22
46-55	$8.88	$2.22	$11.10
56-70	$12.00	$2.46	$14.46

One Parent Family

Age	Premium	FOBBR	Total
18-35	$4.56	$1.08	$5.64
36-45	$6.60	$1.98	$8.58
46-55	$9.18	$2.28	$11.46
56-70	$12.24	$2.58	$14.82

Insured/Spouse

Age	Premium	FOBBR	Total
18-35	$5.88	$2.04	$7.92
36-45	$9.78	$3.78	$13.56
46-55	$14.70	$4.44	$19.14
56-70	$21.54	$4.92	$26.46

Two Parent Family

Age	Premium	FOBBR	Total
18-35	$6.78	$2.10	$8.88
36-45	$10.86	$3.90	$14.76
46-55	$15.96	$4.50	$20.46
56-70	$23.04	$5.04	$28.08

FOBBR: First Occurrence Building Benefit Rider (Rider Form A74050FL)

CRITICAL CARE PROTECTION POLICY - Series A74200

Individual

Age	Premium	FOBBR	Total
18-35	$7.20	$1.02	$8.22
36-45	$10.20	$1.86	$12.06
46-55	$13.92	$2.22	$16.14
56-70	$17.94	$2.46	$20.40

One Parent Family

Age	Premium	FOBBR	Total
18-35	$12.18	$1.08	$13.26
36-45	$14.46	$1.98	$16.44
46-55	$18.60	$2.28	$20.88
56-70	$24.48	$2.58	$27.06

Insured/Spouse

Age	Premium	FOBBR	Total
18-35	$13.80	$2.04	$15.84
36-45	$17.94	$3.78	$21.72
46-55	$24.18	$4.44	$28.62
56-70	$33.66	$4.92	$38.58

Two Parent Family

Age	Premium	FOBBR	Total
18-35	$15.66	$2.10	$17.76
36-45	$19.92	$3.90	$23.82
46-55	$26.58	$4.50	$31.08
56-70	$36.54	$5.04	$41.58

FOBBR: First Occurrence Building Benefit Rider (Rider Form A74050FL)

Mario Zingales
Office:954-474-4108/Fax:954-474-4305
support@fsgsfl.com

CITY OF SUNRISE
AFLAC
DEDUCTION FORM

Employee Name (Last, First, MI)			SS # (Last 4 Digits)		Effective Date	
☐ Enrollment ☐ Discontinue Coverage						
☐ Change Coverage ☐ Open Enrollment						
			Prior Deduction		Newly Elected Deduction	
PLANS			Pre-Tax	Post-Tax	Pre-Tax	Post-Tax
CRITICAL CARE PROTECTION OPT1 - A74175 (including applicable riders, if any)			$	N/A	$	N/A
CRITICAL CARE PROTECTION OPT2 - A74275 (including applicable riders, if any)			$	N/A	$	N/A
SHORT-TERM DISABILITY - A57675 (including applicable riders, if any)			N/A	$	N/A	$
ACCIDENT ADVANTAGE OPT2 - A36275 (including applicable riders, if any)			$	N/A	$	N/A
ACCIDENT ADVANTAGE OPT3 - A36375 (including applicable riders, if any)			$	N/A	$	N/A
CANCER PROTECTION OPT1 - B70175 (including applicable riders, if any)			$	N/A	$	N/A
CANCER PROTECTION OPT2 - B70275 (including applicable riders, if any)			$	N/A	$	N/A

REMARKS:

EMPLOYEE SIGNATURE

DATE

APPROVAL/DATE SENT TO PAYROLL
(Risk Use Only)

HTE ENTERED DATE
(Payroll Use Only)