



## 2022 EMPLOYEE BENEFITS OPEN ENROLLMENT

It's that time of year again, time for Open Enrollment! What is Open Enrollment?

Open enrollment is your opportunity to make changes to your Insurance, including adding or deleting eligible dependents, discontinuing coverage, changing between plans, updating beneficiary forms, or electing new coverage for the first time.

January 1, 2022 marks the start of the new plan year for medical, dental, and vision insurance. Our insurance carriers remain the same; AvMed (Medical), MetLife (Dental), Humana (Vision), The Standard (Life Insurance), and Aflac (Supplemental). **ADDITIONALLY, THERE ARE NO PREMIUM RATE INCREASES.**

This year is a Passive Open Enrollment. Meaning, if you are not making any changes to your existing coverage, you will be automatically re-enrolled and **NO ACTION IS REQUIRED ON YOUR PART.**

### OPEN ENROLLMENT SESSIONS

LOCATION	ADDRESS	DATE	TIME
City Hall – Commission Chambers	10770 W Oakland Park Blvd	Monday 10/18 Wednesday 10/20 Friday 10/22	10:00am – 2:00pm
Annex – Osprey Room	1601 NW 136 <sup>th</sup> Ave, Bldg. A	Tuesday 10/19	10:00am – 2:00pm
Gas Department	4401 NW 103rd Ave	Thursday 10/21	10:00am – 2:00pm
Utilities Administration	777 Sawgrass Corp Pkwy	Monday 10/25	10:00am – 2:00pm
Public Safety Building – Police Community Room	10440 W Oakland Park Blvd	Tuesday 10/26	2:00pm – 6:00pm
Public Works	10500 NW 55 <sup>th</sup> St	Wednesday 10/27	10:00am – 2:00pm
Public Safety Building – Police Community Room	10440 W Oakland Park Blvd	Thursday 10/28	10:00am – 2:00pm

**Due to COVID-19 there will be NO wellness activities.**

Open Enrollment information is available on both CityConnect (City's intranet) under City Announcements and on the City's website ([www.sunrisefl.gov](http://www.sunrisefl.gov)) under Departments/Finance & Administrative Services/Risk Management.

**Documents REQUIRED to enroll eligible dependents are; Marriage Certificate, Birth Certificates, and Social Security Cards.**

Enrollment forms will be accepted via email at [RiskManagement@sunrisefl.gov](mailto:RiskManagement@sunrisefl.gov), regular mail, hand delivery during open enrollment sessions, or to Risk Management on the 3<sup>rd</sup> floor of City Hall. **ALL applications must be submitted to Risk Management by 5:00 PM on November 12, 2021.** For additional information, please contact Joyce Lara, Employee Benefits Specialist, at 954.838.4528 or [jlara@sunrisefl.gov](mailto:jlara@sunrisefl.gov)

**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  
 Effective January 1, 2022**

<b>Health - AvMed</b>	<b>Employee Bi-Weekly Deduction</b>	
	Employee Only	Employee + 1 or More Dependents
HMO	0.00	175.01
POS	92.66	413.49

<b>Dental - MetLife</b>	<b>Employee Bi-Weekly Deduction</b>		
	Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
HMO	7.80	13.65	21.44
PPO Low (\$1,000)	13.74	26.03	40.76
PPO High (\$2,000)	21.51	40.74	63.79

<b>Vision</b>	<b>Employee Bi-Weekly Deduction</b>	
	Employee Only	Employee + 1 or More Dependents
Humana	3.05	7.40

**City of Sunrise Florida**  
**Employee Group Medical, Dental and Vision Plan**

New Enrollment       Reinstatement  
 Open Enrollment       Change

**OFFICE USE ONLY**  
 Effective Date of Coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_      Classification: \_\_\_\_\_

<b>Subscriber Information</b>					
Employee Last Name	First Name	M.I.	Social Security Number*	Date of Birth	Gender __M __F
Mailing Address	Apt.	City	State	Zip	Personal Cell Phone ( ) ____-____
Department/Division	Job Title	Date of Hire		Personal Email:	

**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 medical, 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		<input type="checkbox"/> Add Medical <input type="checkbox"/> Drop Medical <input type="checkbox"/> Add Dental <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add Vision <input type="checkbox"/> Drop Vision DHMO Facility # _____
(3) Dependent			MM-DD-YY	__M __F		<input type="checkbox"/> Add Medical <input type="checkbox"/> Drop Medical <input type="checkbox"/> Add Dental <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add Vision <input type="checkbox"/> Drop Vision DHMO Facility # _____
(4) Dependent			MM-DD-YY	__M __F		<input type="checkbox"/> Add Medical <input type="checkbox"/> Drop Medical <input type="checkbox"/> Add Dental <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add Vision <input type="checkbox"/> Drop Vision DHMO Facility # _____
(5) Dependent			MM-DD-YY	__M __F		<input type="checkbox"/> Add Medical <input type="checkbox"/> Drop Medical <input type="checkbox"/> Add Dental <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add Vision <input type="checkbox"/> Drop Vision DHMO Facility # _____
(6) Dependent			MM-DD-YY	__M __F		<input type="checkbox"/> Add Medical <input type="checkbox"/> Drop Medical <input type="checkbox"/> Add Dental <input type="checkbox"/> Drop Dental <input type="checkbox"/> Add Vision <input type="checkbox"/> 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



 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](http://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](http://www.cciio.cms.gov) or call 1-844-263-2369 to request a copy.

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

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

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 <a href="#">provider's</a> 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.
	<a href="#">Specialist</a> visit	\$35 copay/ visit	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.avmed.org">www.avmed.org</a>	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.
	Preferred brand drugs (Tier 2)	\$50 copay/ prescription (retail); \$100 copay/ prescription (mail order)	Not Covered	Certain drugs in all tiers require prior authorization.
	Non-preferred brand drugs (Tier 3)	\$75 copay/ prescription (retail); \$150 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply.
	Specialty drugs (Tier 4)	25% coinsurance (retail only)	Not Covered	Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order.

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	<a href="#">Emergency room care</a>	\$200 copay/ visit	\$200 copay/ visit	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted.
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	-----None-----
	<a href="#">Urgent care</a>	\$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	<a href="#">Home health care</a>	\$15 copay/ visit	Not Covered	Limited to 60 skilled visits per calendar year. Approved treatment plan required.
	<a href="#">Rehabilitation services</a>	\$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.
	<a href="#">Habilitation services</a>	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.
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Limited to 100 days post-hospitalization care per calendar year. Prior authorization required.
	<a href="#">Durable medical equipment</a>	No charge for DME supplied on an outpatient basis	Not Covered	Some limitations apply. Please see your Summary Plan Description for details.
	<a href="#">Hospice services</a>	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         | • Hearing Aids                                       | • Private-Duty Nursing     |
| • Bariatric Surgery   | • Infertility Treatment                              | • Routine Eye Care (Adult) |
| • Cosmetic Surgery    | • Long-Term Care                                     | • Routine Foot Care        |
| • Dental Care (Adult) | • Non-Emergency Care When Traveling Outside the U.S. | • 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.flair.com/consumers](http://www.flair.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](http://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](http://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](http://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](http://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.flair.com/consumers](http://www.flair.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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$35	■ Specialist copayment	\$35	■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$100	■ Hospital (facility) copayment	\$100	■ Hospital (facility) copayment	\$100
■ Other payment	\$0	■ Other payment	\$0	■ Other copayment	\$0
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/delivery professional services                      Childbirth/delivery facility services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,300</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$200	Copayments	\$1,300	Copayments	\$500
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$260</b>	<b>The total Joe would pay is</b>	<b>\$1,320</b>	<b>The total Mia would pay is</b>	<b>\$500</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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

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

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 <a href="#">provider's</a> 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.
	<a href="#">Specialist</a> visit	\$60 copay/ visit	40% coinsurance after deductible	Additional charges may apply for non-preventive services performed in the Physician's office.
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.avmed.org">www.avmed.org</a>	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.
	Preferred brand drugs (Tier 2)	\$50 copay/ prescription (retail); \$100 copay/ prescription (mail order)	Not Covered	Certain drugs in all tiers require prior authorization.
	Non-preferred brand drugs (Tier 3)	\$75 copay/ prescription (retail); \$150 copay/ prescription (mail order)	Not Covered	Brand additional charges may apply.
	Specialty drugs (Tier 4)	25% coinsurance	50% coinsurance	Specialty and cost-sharing drugs available in 30-day supply only; not available via mail order.

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	<a href="#">Emergency room care</a>	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.
	<a href="#">Emergency medical transportation</a>	20% coinsurance after deductible	20% coinsurance after deductible	-----None-----
	<a href="#">Urgent care</a>	\$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	<a href="#">Home health care</a>	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 60 skilled visits per calendar year. Approved treatment plan required.
	<a href="#">Rehabilitation services</a>	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.
	<a href="#">Habilitation services</a>	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.
	<a href="#">Skilled nursing care</a>	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 100 days post-hospitalization care per calendar year. Prior authorization required.
	<a href="#">Durable medical equipment</a>	20% coinsurance after deductible	40% coinsurance after deductible	Some limitation apply. Please see your Summary Plan Description for details.
	<a href="#">Hospice services</a>	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         | • Hearing Aids                                       | • Private-Duty Nursing     |
| • Bariatric Surgery   | • Infertility Treatment                              | • Routine Eye Care (Adult) |
| • Cosmetic Surgery    | • Long-Term Care                                     | • Routine Foot Care        |
| • Dental Care (Adult) | • Non-Emergency Care When Traveling Outside the U.S. | • 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.flair.com/consumers](http://www.flair.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](http://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](http://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](http://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](http://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.flair.com/consumers](http://www.flair.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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500
■ Specialist copayment	\$60	■ Specialist copayment	\$60	■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/delivery professional services                      Childbirth/delivery facility services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$500	Deductibles	\$0	Deductibles	\$500
Copayments	\$100	Copayments	\$1,400	Copayments	\$300
Coinsurance	\$1,400	Coinsurance	\$0	Coinsurance	\$400
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,060</b>	<b>The total Joe would pay is</b>	<b>\$1,420</b>	<b>The total Mia would pay is</b>	<b>\$1,200</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

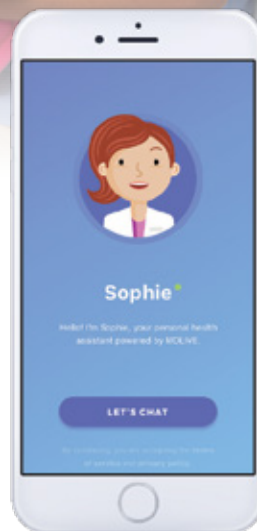


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# Avoid the wait. Your life is 24/7. Now your doctor is too.

It's midnight, and someone in your house has awakened feeling awful. But the emergency room might mean an all-night wait – not to mention an expensive bill. Schedule a virtual visit with a caring AvMed Virtual Visits doctor. We can treat non-emergency symptoms from the comfort of your own home, without the wait. Doesn't that feel better already?



## SIGN UP WITH SOPHIE

Meet Sophie, your Personal Health Assistant! Sophie makes it quick and easy to create an account, schedule a visit and download our mobile app.

### What you get with AvMed Virtual Visits.



See a doctor  
by video or phone  
24/7/365.



Board-certified and  
licensed doctors with an  
average of 15 years of  
experience.



Doctors can send  
prescriptions  
right to the nearest  
pharmacy.

### Why use AvMed Virtual Visits?



The nation's  
largest telehealth  
network.



Quality care  
on your  
schedule.



Private  
and secure  
consultations.



Peace of mind for  
you and your  
family.

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# Evite la espera. Su vida es 24/7. Y ahora su médico también lo es.

Es medianoche y alguien en su casa se despertó sintiéndose muy mal, pero la sala de emergencias pudiera implicar una espera de toda la noche, sin hablar de una factura muy costosa. Programe una visita virtual con un médico de visitas virtuales de AvMed. Podemos tratar los síntomas que no sean de emergencia desde la comodidad de su hogar, sin la espera. ¿Será que ya se siente mejor?

## Lo que usted recibe con las visitas virtuales de AvMed.



Ver a un médico por video o teléfono, 24 horas al día, 7 días a la semana, todo el año.



Médicos certificados con un promedio de 15 años de experiencia.



Los médicos pueden enviar las recetas directamente a la farmacia más cercana.

## ¿Por qué usar las visitas virtuales de AvMed?



La red de salud virtual más grande del país.



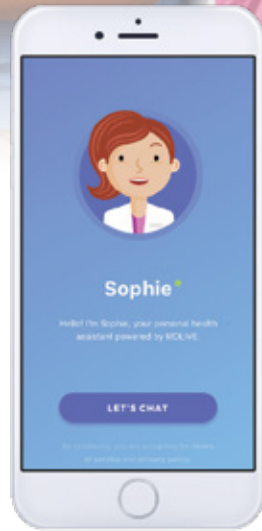
Atención de calidad según su propio horario.



Consultas privadas y seguras.



Tranquilidad para usted y su familia.



## INSCRÍBASE CON SOPHIE

Conozca a Sophie. Sophie, su asistente de salud personal, hace que sea rápido y fácil crear una cuenta, programar una visita y descargar nuestra aplicación móvil.

**Envíe el mensaje 635-483  
a AVMED**



**MDLIVE.com/AvMed 800-400-MDLIVE**

DESCARGUE LA APLICACIÓN



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# DENTAL INSURANCE





## 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
<b>Diagnostic Treatment</b>		
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
<b>Radiographs/Diagnostic Imaging (X-rays)</b>		
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)**

<b>Code</b>	<b>Service</b>	<b>Co-payment</b>
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	\$0
<b>Tests and Examinations</b>		
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
<b>Preventive Services</b>		
D1110	Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors *	\$0
•	Additional-adult prophylaxis (maximum of 2 additional per year)	\$35
D1120	Removal of plaque, calculus and stains from the tooth structures and implants in the primary and transitional dentition. It is intended to control local irritational factors.*	\$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 – per quadrant Excludes a distal shoe space maintainer.	\$25
D1516	Space maintainer – fixed – bilateral, maxillary	\$25
D1517	Space maintainer – fixed – bilateral, mandibular	\$25
D1520	Space maintainer – removable, unilateral – per quadrant	\$35
D1526	Space maintainer – removable – bilateral, maxillary	\$35
D1527	Space maintainer – removable – bilateral, mandibular	\$35
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	\$15
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	\$15
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	\$15
D1556	Removal of fixed unilateral space maintainer – per quadrant	\$15

## SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D1557	Removal of fixed bilateral space maintainer - maxillary	\$15
D1558	Removal of fixed bilateral space maintainer - mandibular	\$15
<b>Restorative Treatment</b>		
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
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
<b>Crowns</b>		
	<ul style="list-style-type: none"> <li>• <i>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.</i></li> <li>• <i>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.</i></li> </ul>	
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 – $\frac{3}{4}$ resin-based composite (indirect)	\$245
D2720	Crown – resin with high noble metal	\$245



## SCHEDULE OF BENEFITS (CONTINUED)

<b>Code</b>	<b>Service</b>	<b>Co-payment</b>
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
D2753	Crown - porcelain fused to titanium and titanium alloys	\$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
D2791	Crown – full cast predominantly base metal	\$245
D2792	Crown – full cast noble metal	\$245
D2794	Crown - titanium and titanium alloys	\$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
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	\$123
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
	<b>Endodontics</b>	
	<i>All procedures exclude final restoration.</i>	
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

**SCHEDULE OF BENEFITS (CONTINUED)**

<b>Code</b>	<b>Service</b>	<b>Co-payment</b>
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
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
D3471	Surgical repair of root resorption –anterior	\$42
D3472	Surgical repair of root resorption – premolar	\$60
D3473	Surgical repair of root resorption – molar	\$72
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
<b>Periodontics</b>		
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	\$95

## SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	quadrant	
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 edentulous tooth position in same graft site	\$380
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
	<ul style="list-style-type: none"> <li>Unspecified periodontal procedure, by report Periodontal hygiene instruction</li> </ul>	\$0
	<b>Removable Prosthodontics</b>	
	<ul style="list-style-type: none"> <li><i>Includes up to 3 adjustments within 6 months of delivery.</i></li> </ul>	
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 retentive/clasping materials, rests and teeth)	\$425
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$425
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	\$400
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping	\$400

## SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	\$425
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	\$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
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	\$150
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	\$150
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
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

## SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
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
<b>Crowns/Fixed Bridges - Per Unit</b>		
	<ul style="list-style-type: none"> <li>• <i>An additional charge will be applied for any procedure using noble or high noble metal.</i></li> <li>• <i>Cases involving 7 or more crowns in the same treatment plan require additional \$125 member fee per unit in addition to co-pay.</i></li> </ul>	
D6210	Pontic – cast high noble metal	\$245
D6211	Pontic – cast predominantly base metal	\$245
D6212	Pontic – cast noble metal	\$245
D6214	Pontic – titanium and titanium alloys	\$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
D6243	Pontic – porcelain fused to titanium and titanium alloys	\$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
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

## SCHEDULE OF BENEFITS (CONTINUED)

<b>Code</b>	<b>Service</b>	<b>Co-payment</b>
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
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	\$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
D6784	Retainer crown – ¾ titanium and titanium alloys	\$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 and titanium alloys	\$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
<b>Oral Surgery</b>		
	<ul style="list-style-type: none"> <li>• <i>Includes routine post operative visits/treatment.</i></li> <li>• <i>The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.</i></li> </ul>	
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 and including elevation of mucoperiosteal flap if indicated	\$30
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	\$40

## SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	spaces, per quadrant	
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
D7961	Buccal / labial frenectomy (frenulectomy)	\$50
D7962	Lingual frenectomy (frenulectomy)	\$50
D7963	Frenuloplasty	\$50
D7970	Excision of hyperplastic tissue – per arch	\$55
D7971	Excision of pericoronal gingiva	\$40
	<b>Orthodontics</b>	
	<ul style="list-style-type: none"> <li>• <i>Benefits cover 24 months of usual &amp; customary orthodontic treatment and 24 months of retention.</i></li> <li>• <i>Comprehensive orthodontic benefits include all phases of treatment and fixed/removable appliances.</i></li> </ul>	
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
D8698	Re-cement or re-bond fixed retainer – maxillary	\$0
D8699	Re-cement or re-bond fixed retainer – mandibular	\$0
D8999	Unspecified orthodontic procedure, by report Orthodontic treatment plan	\$250

## SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	
•	Unspecified orthodontic procedure, by report Ortho visits beyond 24 months of active treatment or retention	\$25 per visit
	<b>Adjunctive General Services</b>	
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
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 adjunctive 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.

<b>Amalgam:</b>	A silver filling
<b>Anterior:</b>	Teeth that are in the front of the mouth
<b>Bicuspid:</b>	Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.
<b>Bridge:</b>	A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).
<b>Crown:</b>	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.
<b>Endodontics:</b>	Procedures that treat the nerve or the pulp of the tooth due to injury or infection.
<b>Oral Surgery:</b>	Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.
<b>Orthodontics:</b>	Braces and other procedures to straighten the teeth.
<b>Periodontics:</b>	Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).
<b>Posterior:</b>	Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).
<b>Primary Teeth:</b>	The first set of teeth (“baby” teeth).
<b>Prophylaxis:</b>	Scaling and polishing of teeth by removal of the plaque above the gum line.
<b>Prosthodontics:</b>	The restoration of natural and/or the replacement of missing teeth with artificial substitutes.
<b>Quadrant:</b>	One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).
<b>Resin-based Composite:</b>	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.

## Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

City of Sunrise

### Network: PDP Plus

Coverage Type	Plan option 1 PPO Plan		Plan option 2 Enhanced Plan	
	In-Network % of Negotiated Fee*	Out-of-Network % of Scheduled Amount**	In-Network % of Negotiated Fee*	Out-of-Network % of R&C Fee***
<b>Type A: Preventive</b> (cleanings, exams, X-rays)	100%	100%	100%	100%
<b>Type B: Basic Restorative</b> (fillings, extractions, X-rays)	80%	80%	80%	80%
<b>Type C: Major Restorative</b> (bridges, dentures)	50%	50%	50%	50%
<b>Type D: Orthodontia</b>	50%	50%	50%	50%

Deductible†	Plan option 1 PPO Plan		Plan option 2 Enhanced Plan	
Individual	\$50	\$50	\$50	\$50
Family	\$150	\$150	\$150	\$150
<b>Annual Maximum Benefit</b>				
Per Person	\$1,000	\$1,000	\$2,000	\$2,000
<b>Orthodontia Lifetime Maximum</b>				
Per Person	\$1,000	\$1,000	\$2,000	\$2,000

**Child(ren)'s eligibility** for dental coverage is from birth up to age 26.

\*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.

\*\*Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.

\*\*\*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.

†Applies only to Type B & C Services.



## Dental Insurance

### 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 Type	Plan Option 1: PPO Plan How Many/How Often	Plan Option 2: Enhanced Plan How Many/How Often
<b>Type A — Preventive</b>		
Prophylaxis (cleanings)	One per 6 months	One per 6 months
Oral Examinations	One exam per 6 months	One exam per 6 months
Topical Fluoride Applications	One fluoride treatment per 12 months for dependent children up to his/her 14th birthday	One fluoride treatment per 12 months for dependent children up to his/her 14th birthday
X-rays	<ul style="list-style-type: none"> <li>Bitewings X-rays; one set per 12 months</li> </ul>	<ul style="list-style-type: none"> <li>Bitewings X-rays; one set per 12 months</li> </ul>
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday, once per tooth area per lifetime	Space maintainers for dependent children up to his/her 14th birthday, once per tooth area per lifetime
Sealants	One application of sealant material for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 14th birthday	One application of sealant material for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 14th birthday
<b>Type B — Basic Restorative</b>		
Fillings	Once per surface per every 12 months	Once per surface per every 12 months
Simple Extractions		
X-rays	<ul style="list-style-type: none"> <li>Full mouth X-rays; one per 60 months</li> </ul>	<ul style="list-style-type: none"> <li>Full mouth X-rays; one per 60 months</li> </ul>
Endodontics	N/A	Codes 3110-3222: Root canal treatment limited to once per tooth per 24 months
Periodontics	N/A	<ul style="list-style-type: none"> <li>Periodontal scaling and root planing once per quadrant, every 36 months</li> <li>Total number of periodontal maintenance treatments and prophylaxis cannot exceed one treatment per 6 months</li> </ul>

## Dental Insurance

Type C — Major Restorative		
Crown, Denture and Bridge Repair/ Recementations		
Oral Surgery		
Implants	N/A	Replacement once every 5 years
Bridges and Dentures	<ul style="list-style-type: none"> <li>Initial placement to replace one or more natural teeth, which are lost while covered by the plan</li> <li>Dentures and bridgework replacement; one every 84 months</li> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>Initial placement to replace one or more natural teeth, which are lost while covered by the plan</li> <li>Dentures and bridgework replacement; one every 84 months</li> <li>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</li> </ul>
Crowns, Inlays and Onlays	<ul style="list-style-type: none"> <li>Replacement once every 84 months</li> <li>Stainless Steel Crowns limited to once per 36 months to age 16</li> </ul>	<ul style="list-style-type: none"> <li>Replacement once every 84 months</li> <li>Stainless Steel Crowns limited to once per 36 months to age 16</li> </ul>
Endodontics	Root canal treatment limited to once per tooth per 24 months	All other 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	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	<ul style="list-style-type: none"> <li>Periodontal scaling and root planing once per quadrant, every 36 months</li> <li>Periodontal surgery once per quadrant, every 36 months</li> <li>Total number of periodontal maintenance treatments and prophylaxis cannot exceed one treatment per 6 months</li> </ul>	<ul style="list-style-type: none"> <li>Periodontal surgery once per quadrant, every 36 months</li> </ul>

## Dental Insurance

### Type D — Orthodontia

- 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
- 20% 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

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- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis
- 20% 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.

### 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;



## Dental Insurance

- 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 (PPO Plan only);
- Repair of implants (PPO 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 (Enhanced PPO Plan);
- 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.
- Repair or replacement of an orthodontic device;
- 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 1-800-942-0854 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 31 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.

## Dental Insurance

### Questions & Answers

**Q. Who is a participating dentist?**

**A.** 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.<sup>†</sup>

**Q. How do I find a participating dentist?**

**A.** 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](http://www.metlife.com/mybenefits) or call 1-800-942-0854 to have a list faxed or mailed to you.

**Q. What services are covered under this plan?**

**A.** The certificate of insurance sets forth the covered services under the plan. Please review the enclosed plan benefits to learn more.

**Q. May I choose a non-participating dentist?**

**A.** 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.

**Q. Can my dentist apply for participation in the network?**

**A.** 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](http://www.metdental.com), or call 1-866-PDP-NTWK for an application.<sup>††</sup> The website and phone number are for use by dental professionals only.

**Q. How are claims processed?**

**A.** 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](http://www.metlife.com/mybenefits) or request one by calling 1-800-942-0854

**Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?**

**A.** 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](http://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.

**Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?**

**A.** 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.

**Q. How does MetLife coordinate benefits with other insurance plans?**

**A.** 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.

**Q. Do I need an ID card?**

**A.** 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.

## Dental Insurance

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†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.

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 group policy form GPNP99 or contact MetLife.

# Find a Dental Provider

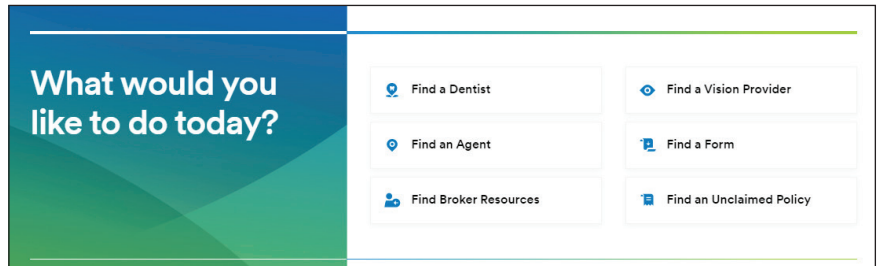
With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.



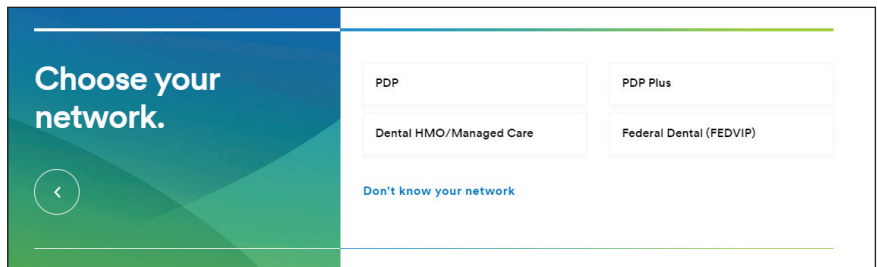
**Step 1:**  
Go to [metlife.com](https://www.metlife.com)



**Step 2:**  
Select "Find a Dentist" next to "What would you like to do today?"



**Step 3:**  
Select "PDP/ PDP Plus" next to "Choose your network."  
Enter your Zip, City or State and select the "Find a Dentist" button.



Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

# Frequently Asked Questions About Preventive Dental Care



## This brochure is intended for your general knowledge.

*This information is not a substitute for visiting a dentist nor does this information replace advice given to you by your physician or dentist.*

*By making this information available to you, MetLife is not engaged in rendering any medical or dental advice.*

*Insofar as the information provided is from third parties, it has no association whatsoever with MetLife, unless expressly stated.*

## What is preventive dental care?

Preventive dental care is all the things you do (or should do) to take care of your teeth and gums: brushing, flossing, eating a healthy diet, and seeing your dentist regularly to help avoid dental disease.

## Why is preventive dental care important?

When it comes to the health of your teeth and gums, preventive dental care is smart. Brushing and flossing help to remove plaque from the surfaces and in between teeth, keeping your teeth looking and feeling clean. A healthy diet, one low in sugar and other refined carbohydrates, helps keep your whole body, including your teeth and gums, in good shape. And routine dental exams and regular cleanings may help prevent the incidence of higher-cost treatments such as periodontal surgery, root canals, extractions and fillings. After all, early detection and prevention are key to minimizing your need for more serious dental treatment.

## How often should I see my dentist?

There are no clear guidelines stating how often a person should see the dentist. Some studies suggest once a year, others say every three or six months. Depending on your current dental health, your dental history, your risk factors for dental disease, and your personal preference, your dentist will recommend the frequency of visits that's right for you.

## What does the American Dental Association say about routine dental care?

- The ADA recommends the following steps for good dental health:<sup>1</sup>
- Brush your teeth twice a day with an ADA-accepted fluoride toothpaste.
- Replace your toothbrush every three or four months, sooner if it shows signs of wear.
- Clean between teeth daily with floss or an interdental cleaner.
- Eat a balanced diet, and limit soft drinks and between-meal snacks.
- Be sure to receive professional cleanings and oral exams on a regular basis.

## What questions should I ask my dentist about routine dental care?

1. Which toothbrush, toothpaste, floss and/or other products do you recommend for my teeth?
2. Based on my dental history and current oral health condition, how many cleanings do you recommend I have each year, and why?
3. Am I at risk for any dental diseases? If so, why? What changes should I make in my routine dental care to help control this risk?

<sup>1</sup> American Dental Association. "Brushing Your Teeth", <http://www.mouthhealthy.org/en/az-topics/b/brushing-your-teeth> Accessed 01/18/2021.



# LIFE INSURANCE



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# 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

## ? 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.

<b>How Much Can I Apply For? *</b> 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:	<b>\$10,000 – \$500,000</b> in increments of <b>\$10,000</b>
	For Your Spouse:	<b>\$5,000 – \$250,000</b> in increments of <b>\$5,000</b>
	For Your Child(ren):	<b>\$2,500 – \$10,000</b> in increments of <b>\$2,500</b>
<b>What is the Guarantee Issue Maximum? **</b> Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions. Initial enrollment means Additional Life is applied for within 31 days of your hire date.	For You:	Up to <b>\$300,000</b> in increments of \$10,000
	For Your Spouse:	Up to <b>\$50,000</b> in increments of \$5,000. This amount may not exceed 50% of Your Additional Life amount.

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

- \* Annual salary is rounded to the next higher multiple of \$1,000 for purposes of computing benefit limit maximum multipliers.
- \*\* Your combined Basic Life and Additional Life amounts cannot exceed a maximum of 6 times your annual salary earnings when determining the Guaranteed Issue Maximum during initial enrollment. Initial enrollment period means within 31 days of hire date.
- \*\* Your Guarantee Issue Maximum "For Your Child(ren)" during initial enrollment period is Up to \$10,000 in increments of \$2,500.



## ☰ Additional Feature

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### **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.

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## 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](http://www.standard.com/life/needs).

## 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:



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.

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

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



Group Additional Life Insurance

Employee Life Bi-Weekly Premiums

Coverage Amount	Employee's Age as of last January 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).



Group Additional Life Insurance

Spouse Life Bi-Weekly Premiums

Coverage Amount	Spouse's Age as of last January 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).

## Group Additional Life Insurance

### 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 coverage, you must be:

- An active employee of City of Sunrise
- Regularly working at least 30 hours per week
- 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](http://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](http://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](http://www.standard.com)

SI 12506-D-AL-FL-755780 (10/18)





# Group Accidental Death & Dismemberment Insurance

7b

## 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

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### How Much Can I Apply For?

For You:

**\$10,000 – \$500,000** in increments of  
**\$10,000**

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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<sup>1</sup>

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.

<sup>1</sup> 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:

$$\underline{\hspace{2cm}} \div \$1,000 = \underline{\hspace{2cm}} \times \underline{\hspace{2cm}}$$

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

## Group Accidental Death & Dismemberment Insurance

### Employee AD&D Bi-Weekly Premiums

Coverage Amount	Employee's Age as of January 1st		
	< 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 <sup>1</sup>	100%
One hand or one foot <sup>2</sup>	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 <sup>4</sup>	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](http://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](http://www.standard.com)

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





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 <b>City of Sunrise</b>	Group No. <b>755780</b>	

**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
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Risk Management Department - Retain for your records.

**DIRECTIONS FOR APPLYING FOR COVERAGE**

Read the Information Practices Notice(s) on page 4. 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 3. 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 <b>City of Sunrise</b>		Group Number <b>755780</b>	Check who is Applying (One per form) <input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Member/Employee Name		Birth Date (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/Province	ZIP/Postal Code
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

**APPLICATION INFORMATION**

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

Short Term Disability

Long Term Disability  $\frac{\text{Current Amount In Force, if any}}{\text{Additional Amount Requested}} = \frac{\text{Total Amount Requested}}$

Life  $\frac{\text{Current Amount In Force, if any}}{\text{Additional Amount Requested}} = \frac{\text{Total Amount Requested}}$

Dependents Life  $\frac{\text{Current Amount In Force, if any}}{\text{Additional Amount Requested}} = \frac{\text{Total Amount Requested}}$

**PHYSICIAN INFORMATION** (Physician name or medical facility with Applicant's complete medical records—provide name and full mailing address)

Doctor First Name		Doctor Last Name		
Clinic Name			Doctor Phone	
Doctor Address		City	State/Province	ZIP/Postal Code
Date Last Consulted				
Reason Last Consulted				

Applicant Name	Social Security Number
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**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.**

1. Are you now unable to maintain full time employment as a result of a diagnosis or treatment by a licensed member of the medical profession? .....  Yes  No
2. Has a licensed medical professional 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 disorder, or digestive system disorder? .....  Yes  No
  - B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, deafness, or another neurological or muscle disorder? .....  Yes  No
  - C. Cancer (malignancy or growth), leukemia, lymphoma, chronic anemia, or blood clotting (thrombophlebitis, pulmonary embolism)? .....  Yes  No
  - D. Cardiovascular disease, heart ailment, arteriosclerosis, chest pain, high blood pressure, heart murmur, valve, circulatory or vascular disorder? .....  Yes  No
  - E. Emphysema, asthma, chronic bronchitis, sleep apnea, or other lung disease? .....  Yes  No
  - F. Lupus, scleroderma, vasculitis, connective tissue disease, or other 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, or arthritic conditions? .....  Yes  No
  - H. Endocrine (including thyroid or adrenal), diabetes? .....  Yes  No
  - I. Drug, alcohol or nicotine use or abuse, or have you used drugs, alcohol or nicotine in a manner that resulted in you having to obtain advice, counseling or treatment? .....  Yes  No
  - J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, or obsessive-compulsive disorder? ...  Yes  No
3. 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
4. During the past five years, have you been in a hospital or other institution for observation, rest, diagnosis, or treatment of any disease (not related to Human Immunodeficiency Virus (HIV)), disorder, condition or injury? ....  Yes  No
5. In the next two years, do you plan any operation or visit to a licensed medical professional for an existing physical or mental condition, illness, injury, surgery or pregnancy? .....  Yes  No
6. In the past 7 years, have you received a diagnosis or treatment by a licensed member of the medical profession, which resulted in the use of prescribed medication, other than for a cold or allergies? .....  Yes  No

Height \_\_\_\_\_ Weight \_\_\_\_\_

**DETAILS OF ANY "YES" ANSWERS ABOVE Note: Do not indicate any information regarding treatment for HIV/AIDS/ARC.**

<i>Include diagnosis, start and end dates, duration, type and frequency of treatment, hospitalization, physician visits, cause, location of disorder, residuals, acute or chronic status, work loss, and operations.</i>				
Question #	Diagnosis/Description	Month/Year	Details/Current Status	Physicians Consulted, City and State



Applicant Name	Social Security Number
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**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 supplemental information, are true and complete to the best of my knowledge and belief, 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, pharmacy benefit manager, 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 authorize The Standard to 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 Fraud Notice (if applicable), and I have made 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 felony of the third degree.

<b>Signature of Applicant</b> (or Member/Employee for Dependent Child)	<b>Date</b>
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*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
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**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](http://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.

# VISION INSURANCE

# HumanaVision

City of Sunrise



Humana<sup>®</sup>



Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
<b>Exam with dilation as necessary</b> <ul style="list-style-type: none"> <li>Retinal imaging<sup>1</sup></li> </ul>	\$10 Up to \$39	Up to \$30 Not covered
<b>Contact lens exam options<sup>2</sup></b> <ul style="list-style-type: none"> <li>Standard contact lens fit and follow-up</li> <li>Premium contact lens fit and follow-up</li> </ul>	Up to \$55 10% off retail	Not covered Not covered
<b>Frames<sup>3</sup></b>	Up to \$150 20% off balance over \$150	Up to \$65
<b>Standard plastic lenses<sup>4</sup></b> <ul style="list-style-type: none"> <li>Single vision</li> <li>Bifocal</li> <li>Trifocal</li> <li>Lenticular</li> </ul>	\$15 \$15 \$15 \$15	Up to \$25 Up to \$40 Up to \$60 Up to \$100
<b>Covered lens options<sup>4</sup></b> <ul style="list-style-type: none"> <li>UV coating</li> <li>Tint (solid and gradient)</li> <li>Standard scratch-resistance</li> <li>Standard polycarbonate - adults</li> <li>Standard polycarbonate - children &lt;19</li> <li>Standard anti-reflective coating</li> <li>Premium anti-reflective coating                             <ul style="list-style-type: none"> <li>Tier 1</li> <li>Tier 2</li> <li>Tier 3</li> </ul> </li> <li>Standard progressive (add-on to bifocal)</li> <li>Premium progressive                             <ul style="list-style-type: none"> <li>Tier 1</li> <li>Tier 2</li> <li>Tier 3</li> <li>Tier 4</li> </ul> </li> <li>Photochromatic / plastic transitions</li> <li>Polarized</li> </ul>	\$15 \$15 \$15 \$40 \$40 \$45 Premium anti-reflective coatings as follows: \$57 \$68 80% of charge \$15 Premium progressives as follows: \$110 \$120 \$135 \$90, 80% of charge, then up to \$120 \$75 20% off retail	Not covered Not covered Not covered Not covered Not covered Not covered Premium anti-reflective coatings as follows: Not covered Not covered Not covered Up to \$40 Premium progressives as follows: Not covered Not covered Not covered Not covered Not covered Not covered
<b>Contact lenses<sup>5</sup> (applies to materials only)</b> <ul style="list-style-type: none"> <li>Conventional</li> <li>Disposable</li> <li>Medically necessary</li> </ul>	Up to \$150, 15% off balance over \$150 Up to \$150 \$0	Up to \$104 Up to \$104 Up to \$200

## Vision care services

**If you use an  
IN-NETWORK provider  
(Member cost)**

**If you use an  
OUT-OF-NETWORK provider  
(Reimbursement)**

	<b>If you use an IN-NETWORK provider (Member cost)</b>	<b>If you use an OUT-OF-NETWORK provider (Reimbursement)</b>
<b>Frequency</b> <ul style="list-style-type: none"> <li>Examination</li> <li>Lenses or contact lenses</li> <li>Frame</li> </ul>	Once every 12 months Once every 12 months Once every 24 months	Once every 12 months Once every 12 months Once every 24 months
<b>Diabetic Eye Care: care and testing for diabetic members</b> <ul style="list-style-type: none"> <li>Examination               <ul style="list-style-type: none"> <li>Up to (2) services per year</li> </ul> </li> <li>Retinal Imaging               <ul style="list-style-type: none"> <li>Up to (2) services per year</li> </ul> </li> <li>Extended Ophthalmoscopy               <ul style="list-style-type: none"> <li>Up to (2) services per year</li> </ul> </li> <li>Gonioscopy               <ul style="list-style-type: none"> <li>Up to (2) services per year</li> </ul> </li> <li>Scanning Laser               <ul style="list-style-type: none"> <li>Up to (2) services per year</li> </ul> </li> </ul>	\$0 \$0 \$0 \$0 \$0	Up to \$77 Up to \$50 Up to \$15 Up to \$15 Up to \$33

<sup>1</sup> Member costs may exceed \$39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.

<sup>2</sup> Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.

<sup>3</sup> Discounts available on all frames except when prohibited by the manufacturer.

<sup>4</sup> Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

<sup>5</sup> Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

### Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.



## Limitations and Exclusions:

- In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:
1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
  2. Services:
    - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
    - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
    - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
  3. Any loss caused or contributed by:
    - War or any act of war, whether declared or not;
    - Any act of international armed conflict; or
    - Any conflict involving armed forces of any international authority.
  4. Any expense arising from the completion of forms.
  5. Your failure to keep an appointment.
  6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
  7. Prescription drugs or pre-medications, whether dispensed or prescribed.
  8. Any service not specifically listed in the Schedule of Benefits.
  9. Any service that we determine:
    - Is not a visual necessity;
    - Does not offer a favorable prognosis;
    - Does not have uniform professional endorsement; or
    - Is deemed to be experimental or investigational in nature.
  10. Orthoptic or vision training.
  11. Subnormal vision aids and associated testing.
  12. Aniseikonic lenses.
  13. Any service we consider cosmetic.
  14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
  15. Services provided by someone who ordinarily lives in your home or who is a family member.
  16. Charges exceeding the reimbursement limit for the service.
  17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
  18. Plano lenses.
  19. Medical or surgical treatment of eye, eyes, or supporting structures.
  20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
  21. Any examination or material required by an Employer as a condition of employment.
  22. Non-prescription sunglasses.
  23. Two pair of glasses in lieu of bifocals.
  24. Services or materials provided by any other group benefit plans providing vision care.
  25. Certain name brands when manufacturer imposes no discount.
  26. Corrective vision treatment of an experimental nature.
  27. Solutions and/or cleaning products for glasses or contact lenses.
  28. Pathological treatment.
  29. Non-prescription items.
  30. Costs associated with securing materials.
  31. Pre- and Post-operative services.
  32. Orthokeratology.
  33. Routine maintenance of materials.
  34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
  35. Artistically painted lenses.

## 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.<sup>1</sup>

<sup>1</sup> Thompson Media Inc.

## Questions?

Check out [Humana.com](https://www.humana.com)

Call 1-866-995-9316 seven days a week: 8 a.m. to 6 p.m. Eastern Time Monday through Saturday, and 11 a.m. to 8 p.m. Sunday.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations. Policy number: FL-70148-01LG9/15et.al.;FL-70148-01SG9/15et.al.

**Humana**<sup>®</sup>

[Humana.com](https://www.humana.com)



# MyHumana Mobile app

Manage your vision care — wherever you are

## Access your health information anytime, anywhere

Whether you prefer downloading a mobile application, using your mobile device or receiving text messages, you have the ability to manage your vision care needs virtually anywhere, anytime.

### Use the MyHumana Mobile app to:

- View your plans and coverage details
- View claims
- View, fax or save ID cards
- Find a optometrist in your network
- 

### Download the Mobile app:

Download the MyHumana Mobile app from your app store. Search “MyHumana” in the Google Play® or App Store®.

†Available to HumanaVitality members only. ‡Available to members who use Humana Pharmacy only.

\*Message and data rates may apply.



### From your mobile device's browser:

You can visit MyHumana from your mobile device's browser. To get started, go to **Humana.com** and sign in.

### Sign up for text message alerts\* on Humana.com

1. Register or sign in (have your Humana ID or Social Security number available)
2. Click on “Account & settings” under My Profile
3. Select “Edit your preferences”
4. Select “Mobile” from the tab
5. Register and verify your mobile number
6. Select the alerts you want to receive

**Humana**®

[Humana.com](http://Humana.com)



# See the bottom line ahead of time

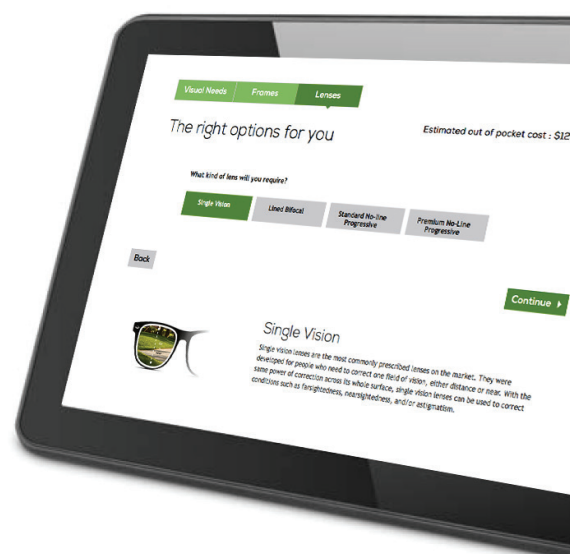
Humana Vision members have access to an industry-first cost transparency tool, which can be accessed via the member web and the MyHumana mobile app.

The dynamic and engaging Know Before You Go cost estimator tool emphasizes the importance of an annual eye exam. It also increases member confidence by explaining the different types of contact and eyeglass lenses, lens materials, and frame categories, as well as some of the most popular lens options.

The member receives an estimated total cost ahead of time, so there are fewer surprises when it's time to pay the provider.

## MEMBERS SEE THEIR ESTIMATED TOTAL IN 3 SIMPLE STEPS

- 1 Sign in and access the Vision home page
- 2 Select the **Estimate costs** tab
- 3 Complete the Know Before You Go out-of-pocket cost estimator activity



Members often have no out-of-pocket costs beyond their copays, and all members will feel better prepared for their visit as a result of estimating their costs ahead of time.

Learn more about how we make vision benefits easy to use. Contact your Humana rep or visit [humana.com](https://www.humana.com).



## Choosing Humana Vision is good for your health

Besides checking for changes in your vision, your eye doctor can check for common eye conditions like glaucoma.

An eye exam can also uncover other health issues, such as high blood pressure and diabetes. If you have diabetes, most Humana Vision plans have additional coverage for the care and testing you need to help manage your condition.

Humana Vision makes good eye health easy and budget friendly

- Get an annual eye exam for \$10
- Choose from more than 70,000 eye doctors in more than 24,000 locations including LensCrafters®, Pearle Vision®, Target Optical and many other private practitioners

Find an eye professional near You



Online Retailers New to Humana Network

Glasses.com / Contacts.com

To find an in-network provider, search at Humana.com

**Humana**

Humana.com



Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.  
GCHJL5CEN 0616

## Helping members see more with their vision benefit

At Humana, we're focused on ensuring members get the most value from their vision benefit:

- Our network offers the right mix of independent, national retail, and regional retail providers, including LensCrafters, Target Optical and Pearle Vision; as well as online, in-network options, such as LensCrafters.com, Glasses.com, ContactsDirect.com, Ray-Ban.com.
- Our vision plans are designed to effectively control out-of-pocket costs, without confusing formularies or limiting restrictions.

And now, members have access to an exclusive list of special offers that provide discounts and rebates on vision care and services above and beyond the vision benefit.

**Examples of currently available special offers\* are listed below. New and updated offers are added quarterly and annually.**

- Additional \$25 off when using your vision insurance at Target Optical
- \$25 towards a complete pair of glasses or Rx sunglasses at Pearle Vision. Can be combined with vision insurance benefits
- \$20 off any purchase or \$50 off purchase of \$200 or more at Sunglass Hut
- 10% off at ContactsDirect.com

*\*Restrictions may apply. Detailed terms and conditions for each available special member offer can be viewed on the Humana Vision Insight member microsite.*

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](mailto:privacyoffice@humana.com)
- Sending a written request to:  
Humana Privacy Office  
P.O. Box 1438  
Louisville, KY 40202

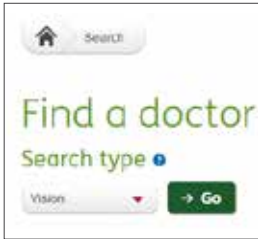


# How to find a vision provider

To see if your vision provider is available with the plan you choose—or if you need to find a vision provider—get started at **Humana.com**.

## NOT A MEMBER

1. Go to **Humana.com** and select **Find a doctor** under the **Member Resources** menu
2. Choose **Vision** search type and select **Go**



3. Select **Vision coverage through your employer or you purchased on your own** and choose **Go**



4. Select **Humana Vision** (Humana Insight Network)



5. Enter your **ZIP code**



## ALREADY A MEMBER

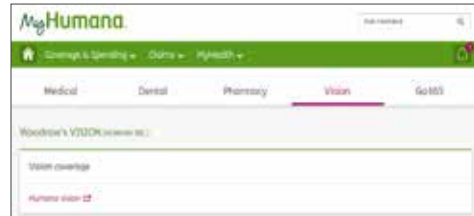
1. Go to **Humana.com** and select **Sign In**



2. Enter your **username** and **password** then select **Sign In**



3. Select the **Vision** tab and choose **Humana Vision**



4. Select **Locate a Provider**



5. Enter your **ZIP code**



## Important!

### At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:  
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618  
If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

### Auxiliary aids and services, free of charge, are available to you.

**1-877-320-1235 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

### Language assistance services, free of charge, are available to you.

**1-877-320-1235 (TTY: 711)**

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resewva sèvis èd pou lang ki gratis.

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**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jii'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

# Ready to see yourself with a new look?

Enjoy the convenience of contact lenses

## Be free from your glasses

Contact lenses are a great option to correct your vision. Your doctor will help you determine if you're a candidate for contact lenses and the type of lenses appropriate for you. Some popular choices include:

### Conventional

Conventional lenses can be rigid, gas permeable material or conventional soft lens material.

### Disposable/frequent replacement

Replacing your contacts on a regular basis may be in your best interest. Your doctor will help you choose from monthly, weekly or daily replacement lenses.

### Bifocal

These correct for distance and near vision at the same time (just like bifocal glasses).

### Toric

With a special curvature designed to correct for astigmatism, toric lenses are used when conventional soft or rigid lenses don't correct the defect.

### Colored or fashion-tinted lenses

Cosmetically tinted lenses are designed to enhance or change a person's eye color. They are very popular among people with light-colored eyes and offer an excellent opportunity to change or enhance eye color.

Most Humana vision plans cover conventional and disposable contact lenses, as well as fitting and follow-up fees. Refer to your plan for more information.



# Humana®

Our vision benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, call or write your Humana insurance agent or broker. Humana group vision plans are offered by Humana Insurance Company, Humana Dental Insurance Company, Humana Health Benefit Plan of Louisiana, Humana Insurance Company of Kentucky, Humana Insurance Company of New York, CompBenefits Insurance Company, CompBenefits Company, or The Dental Concern, Inc. For Colorado: The Network Access Plan, which describes an access plan specific to your network, is available by calling the customer service number found on your Humana Vision ID card and requesting a copy.

GNAOBMOHH 1220

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- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك



# 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](mailto:director@thezro.com) or [Mario@fsgsfl.com](mailto:Mario@fsgsfl.com)

or

**Kimberly H. Finley, Benefit Consultant**  
**AFLAC – Florida Southeast**  
**Tel: 954.320.6016**  
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**AFLAC – SOUTHEAST | Framework Solutions Group**  
**2598 E. Sunrise Blvd., Suite 2104**  
**Fort Lauderdale, FL 33304**

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# 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™

## 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.

When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:

**SPECIFIED-DISEASE BENEFIT 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

<b>EXTENDED-CARE FACILITY</b>	\$100 per day; limited to 30 days in each calendar year, per covered person						
<b>HOME HEALTH CARE</b>	\$100 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person						
<b>HOSPICE CARE</b>	\$1,000 for first day; \$50 per day thereafter; \$12,000 lifetime maximum per covered person						
<b>NURSING SERVICES</b>	\$100 per day; payable for only the number of days the Hospital Confinement Benefit is payable						
<b>SURGICAL PROSTHESIS</b>	\$2,000; lifetime maximum of \$4,000 per covered person						
<b>NONSURGICAL PROSTHESIS</b>	\$175 per occurrence, per covered person; lifetime maximum of \$350 per covered person						
<b>BREAST RECONSTRUCTION</b>	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						
<b>OTHER RECONSTRUCTIVE SURGERY</b>	Facial Reconstruction: \$500 Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit Maximum daily benefit will not exceed \$500						
<b>EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION</b>	\$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						
<b>ANNUAL CARE</b>	\$200 on the anniversary date of diagnosis; lifetime maximum of five annual \$200 payments per covered person						
<b>AMBULANCE</b>	\$250 ground \$2,000 air ambulance						
<b>TRANSPORTATION</b>	\$.40 cents per mile for transportation; payable up to a combined maximum of \$1,200, per round trip						
<b>LODGING</b>	\$65 per day; limited to 90 days per calendar year						
<b>WAIVER OF PREMIUM</b>	Yes						
<b>OPTIONAL RIDERS</b>	<b>DESCRIPTION</b>						
<b>INITIAL DIAGNOSIS BUILDING BENEFIT RIDER</b>	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.  When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:						
<b>SPECIFIED-DISEASE BENEFIT RIDER</b>	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">Initial diagnosis</td> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">Hospitalization</td> </tr> <tr> <td style="text-align: center;">\$2,000</td> <td style="text-align: center;">30 days or less: \$400 per day</td> <td style="text-align: center;">31 days or more: \$800 per day</td> </tr> </table>	Initial diagnosis		Hospitalization	\$2,000	30 days or less: \$400 per day	31 days or more: \$800 per day
Initial diagnosis		Hospitalization					
\$2,000	30 days or less: \$400 per day	31 days or more: \$800 per day					
<b>DEPENDENT CHILD RIDER</b>	\$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

INITIAL ACCIDENT HOSPITALIZATION BENEFIT

ACCIDENT HOSPITAL CONFINEMENT BENEFIT

INTENSIVE CARE UNIT CONFINEMENT BENEFIT

ACCIDENT TREATMENT BENEFIT

AMBULANCE BENEFIT

BLOOD/PLASMA/PLATELETS BENEFIT

MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT

ACCIDENT FOLLOW-UP TREATMENT BENEFIT

THERAPY BENEFIT

APPLIANCES BENEFIT

PROSTHESIS BENEFIT

PROSTHESIS REPAIR OR REPLACEMENT BENEFIT

REHABILITATION FACILITY BENEFIT

HOME MODIFICATION BENEFIT

ACCIDENT SPECIFIC-SUM INJURIES BENEFITS

ACCIDENTAL-DEATH BENEFIT

ACCIDENTAL-DISMEMBERMENT BENEFIT

WELLNESS BENEFIT

FAMILY SUPPORT BENEFIT

ORGANIZED SPORTING ACTIVITY BENEFIT

WAIVER OF PREMIUM BENEFIT

TRANSPORTATION BENEFIT

FAMILY LODGING BENEFIT

## BENEFIT AMOUNT

\$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

\$200 per day, up to 365 days per covered accident, per covered person

Additional \$400 per day for up to 15 days, per covered accident, per covered person

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

\$150 ground ambulance transportation or \$1,000 air ambulance transportation

\$100 once per covered accident, per covered person

\$150 per calendar year, per covered person

\$25 for one treatment per day (up to a max of 6 treatments), per covered accident, per covered person

\$25 for one treatment per day (up to a max of 10 treatments), per covered accident, per covered person

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

\$500 once per covered accident, per covered person

\$500 once per covered person, per lifetime

\$100 per day

\$2,000 once per covered accident, per covered person

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

	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



# 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

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## BENEFIT NAME

INITIAL ACCIDENT HOSPITALIZATION BENEFIT

ACCIDENT HOSPITAL CONFINEMENT BENEFIT

INTENSIVE CARE UNIT CONFINEMENT BENEFIT

ACCIDENT TREATMENT BENEFIT

AMBULANCE BENEFIT

BLOOD/PLASMA/PLATELETS BENEFIT

MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT

ACCIDENT FOLLOW-UP TREATMENT BENEFIT

THERAPY BENEFIT

APPLIANCES BENEFIT

PROSTHESIS BENEFIT

PROSTHESIS REPAIR OR REPLACEMENT BENEFIT

REHABILITATION FACILITY BENEFIT

HOME MODIFICATION BENEFIT

ACCIDENT SPECIFIC-SUM INJURIES BENEFITS

ACCIDENTAL-DEATH BENEFIT

ACCIDENTAL-DISEMBLEMENT BENEFIT

WELLNESS BENEFIT

FAMILY SUPPORT BENEFIT

ORGANIZED SPORTING ACTIVITY BENEFIT

WAIVER OF PREMIUM BENEFIT

TRANSPORTATION BENEFIT

FAMILY LODGING BENEFIT

## BENEFIT AMOUNT

\$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

\$250 per day, up to 365 days per covered accident, per covered person

Additional \$400 per day for up to 15 days, per covered accident, per covered person

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

\$200 ground ambulance transportation or \$1,500 air ambulance transportation

\$200 once per covered accident, per covered person

\$200 per calendar year, per covered person

\$35 for one treatment per day (up to a max of 6 treatments), per covered accident, per covered person

\$35 for one treatment per day (up to a max of 10 treatments), per covered accident, per covered person

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

\$800 once per covered accident, per covered person

\$800 once per covered person, per lifetime

\$150 per day

\$3,000 once per covered accident, per covered person

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

	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



# 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
<b>FIRST-OCCURRENCE BENEFIT:</b>	
Named Insured/Spouse	\$7,500; lifetime maximum \$7,500 per covered person
Dependent Children	\$10,000; lifetime maximum \$10,000 per covered person
<b>SUBSEQUENT SPECIFIED HEALTH EVENT BENEFIT</b>	\$3,500 Subsequent occurrence limitations apply. No lifetime maximum.
<b>CORONARY ANGIOPLASTY BENEFIT</b>	\$1,000 Payable only once per covered person, per lifetime
<b>HOSPITAL CONFINEMENT BENEFIT</b>	\$300 per day No lifetime maximum
<b>AMBULANCE BENEFIT</b>	\$250 ground or \$2,000 air No lifetime maximum
<b>CONTINUING CARE BENEFIT</b>	<p>\$125 each day when a covered person is charged for any of the following treatments:</p> <ul style="list-style-type: none"> <li>• Rehabilitation Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Occupational Therapy</li> <li>• Respiratory Therapy</li> <li>• Dietary Therapy/Consultation</li> <li>• Home Health Care</li> <li>• Dialysis</li> <li>• Hospice Care</li> <li>• Extended Care</li> <li>• Physician Visits</li> <li>• Nursing Home Care</li> </ul> <p>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.</p>
<b>TRANSPORTATION BENEFIT</b>	\$.50 per mile, per covered person whom special treatment is prescribed, for a covered loss Limited to \$1,500 per occurrence; no lifetime maximum
<b>LODGING BENEFIT</b>	Up to \$75 per day, for covered lodging charges Limited to 15 days per occurrence; no lifetime maximum
<b>WAIVER OF PREMIUM BENEFIT</b>	Premium waived, from month to month, during total inability (after 180 continuous days)



# 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 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

#### 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)

# OPTIONAL FIRST-OCCURRENCE BUILDING BENEFIT

## RIDER SUMMARY PAGE

Policy Rider Series A74000

# CCP<sup>R</sup>

## 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 3199  
aflac.com | 1.800.99.AFLAC | 1.800.992.3522

The Aflac logo, featuring the word "Aflac" in a blue, sans-serif font with a small yellow duck head icon above the letter 'i'.



# Aflac Short-Term Disability Insurance

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



Aflac<sup>®</sup>

**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.
<b>OPTIONAL RIDERS</b>	
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





**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				One Parent Family			
Age	Premium	FOBBR	Total	Age	Premium	FOBBR	Total
18-35	\$4.08	\$1.02	\$5.10	18-35	\$4.56	\$1.08	\$5.64
36-45	\$6.36	\$1.86	\$8.22	36-45	\$6.60	\$1.98	\$8.58
46-55	\$8.88	\$2.22	\$11.10	46-55	\$9.18	\$2.28	\$11.46
56-70	\$12.00	\$2.46	\$14.46	56-70	\$12.24	\$2.58	\$14.82

Insured/Spouse				Two Parent Family			
Age	Premium	FOBBR	Total	Age	Premium	FOBBR	Total
18-35	\$5.88	\$2.04	\$7.92	18-35	\$6.78	\$2.10	\$8.88
36-45	\$9.78	\$3.78	\$13.56	36-45	\$10.86	\$3.90	\$14.76
46-55	\$14.70	\$4.44	\$19.14	46-55	\$15.96	\$4.50	\$20.46
56-70	\$21.54	\$4.92	\$26.46	56-70	\$23.04	\$5.04	\$28.08

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

**CRITICAL CARE PROTECTION POLICY - Series A74200**

Individual				One Parent Family			
Age	Premium	FOBBR	Total	Age	Premium	FOBBR	Total
18-35	\$7.20	\$1.02	\$8.22	18-35	\$12.18	\$1.08	\$13.26
36-45	\$10.20	\$1.86	\$12.06	36-45	\$14.46	\$1.98	\$16.44
46-55	\$13.92	\$2.22	\$16.14	46-55	\$18.60	\$2.28	\$20.88
56-70	\$17.94	\$2.46	\$20.40	56-70	\$24.48	\$2.58	\$27.06

Insured/Spouse				Two Parent Family			
Age	Premium	FOBBR	Total	Age	Premium	FOBBR	Total
18-35	\$13.80	\$2.04	\$15.84	18-35	\$15.66	\$2.10	\$17.76
36-45	\$17.94	\$3.78	\$21.72	36-45	\$19.92	\$3.90	\$23.82
46-55	\$24.18	\$4.44	\$28.62	46-55	\$26.58	\$4.50	\$31.08
56-70	\$33.66	\$4.92	\$38.58	56-70	\$36.54	\$5.04	\$41.58

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

**ONLY COMPLETE IF ELECTING VOLUNTARY AFLAC SUPPLEMENTAL PLANS**

CITY OF SUNRISE  
AFLAC  
DEDUCTION FORM

Employee Name (Last, First, MI)		SS # (Last 4 Digits)		Effective Date	
<input type="checkbox"/> Enrollment	<input type="checkbox"/> Discontinue Coverage				
<input type="checkbox"/> Change Coverage	<input type="checkbox"/> Open Enrollment				
PLANS		Tyler Munis Codes	Prior Deduction	New Deduction	
			Pre-Tax	Post-Tax	Pre-Tax
					Post-Tax
CRITICAL CARE PROTECTION OPT1 - A74175		2337	\$	N/A	\$ N/A
CRITICAL CARE PROTECTION OPT2 - A74275		2337	\$	N/A	\$ N/A
SHORT-TERM DISABILITY - A57675		8120	N/A	\$	N/A \$
ACCIDENT ADVANTAGE OPT2 - A36275		2338	\$	N/A	\$ N/A
ACCIDENT ADVANTAGE OPT3 - A36375		2338	\$	N/A	\$ N/A
CANCER PROTECTION OPT1 - B70175		2336	\$	N/A	\$ N/A
CANCER PROTECTION OPT2 - B70275		2336	\$	N/A	\$ N/A

REMARKS: Manually enter premiums in Tyler Munis.

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\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
APPROVAL/DATE SENT TO PAYROLL  
(Risk Use Only)

\_\_\_\_\_  
HTE ENTERED DATE  
(Payroll Use Only)