2025 Employee Benefits Open Enrollment

October 1st – October 31st, 2024

January 1st, 2025 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), and AFLAC (Supplemental). All bi-weekly insurance premiums remain unchanged.
No Action Needed If Not Making Changes.

Wellness Activities: Flu Shots, Massages, Skin and Vision Testing

LOCATION	ADDRESS	DATE	TIME
Public Safety Building – Police Community Room	10440 W Oakland Park Blvd	Wednesday 10/23/24*	10:00am – 2:00pm
Utilities Administration – 2nd Floor Conference Room	777 Sawgrass Corp Pkwy	Tuesday 10/29/24*	10:00am – 2:00pm

*On select days and locations (as asterisked above) members of the Human Resources team will be in attendance to provide valuable information about several key City programs, including:

- **Tuition Reimbursement**: Learn how you can get financial assistance from the City for your degree-seeking courses to further your education and enhance your skills.
- **Public Service Loan Forgiveness (PSLF)**: We will guide you to the resources you need to get started with this federal program, which could help you reduce or eliminate your student loan debt.
- **Toastmasters International - Professional Development Club**: Find out how you can improve your public speaking, communication, and leadership skills through our Toastmasters International club – the **Rising Stars Society**!
- **City Initiative: "Three Pillars"**: Learn about our city's commitment to core values of **Customer Service**, **Collaboration**, and **Transparency** through the "Three Pillars" initiative and how these values are being integrated across city departments to enhance service delivery and foster a culture of cooperation and openness.

Don't miss this opportunity to meet with your Risk Management and HR team, ask questions, and learn how these programs can benefit you. We look forward to seeing you!

For additional information contact Joyce Lara, Employee Benefits Specialist at 954.838.4528 or 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, 2025

Health - AvMed	Employee Bi-Weekly Deduction		Overage Dependent*
	Employee Only	Employee + 1 or More Dependents	Each Dependent
HMO	$0.00	$175.01	$722.77
POS	$92.66	$413.49	$923.54
***Overage Dependent:** Additional monthly premium for each dependent age 26 - 30 will be added to employees bi-weekly deductions. Overage dependent premiums are 100% employee paid on a post-tax basis.			

Dental - MetLife	Employee Bi-Weekly Deduction		
	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

Vision	Employee Bi-Weekly Deduction	
	Employee Only	Employee + 1 or More Dependents
Humana Low	$3.05	$7.40
Humana High	$4.37	$10.61

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

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

Employee Information

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**

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-PPO Low	Dental-PPO High	Vision Low	Vision High
Indicate your medical, dental and/or vision coverage options by placing an X in the appropriate ( )							
Single	( )	( )	( )	( )	( )	( )	( )
Employee and One Dependent*			( )	( )	( )		
Family	( )	( )	( )	( )	( )	( )	( )

*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		___Add Medical ___Drop Medical ___EE Declined ___Add Dental ___Drop Dental ___EE Declined ___Add Vision ___Drop Vision ___EE Declined ___No Change
(3) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___EE Declined ___Add Dental ___Drop Dental ___EE Declined ___Add Vision ___Drop Vision ___EE Declined ___No Change
(4) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___EE Declined ___Add Dental ___Drop Dental ___EE Declined ___Add Vision ___Drop Vision ___EE Declined ___No Change
(5) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___EE Declined ___Add Dental ___Drop Dental ___EE Declined ___Add Vision ___Drop Vision ___EE Declined ___No Change
(6) Dependent	MM-DD-YY	___M ___F		___Add Medical ___Drop Medical ___EE Declined ___Add Dental ___Drop Dental ___EE Declined ___Add Vision ___Drop Vision ___EE Declined ___No Change

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 ___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**_____

REVISED10/23

Important Notice from City of Sunrise
Medicare RX Coverage Creditable Coverage Notice
Medical Plan Year 01/01/2025 – 12/31/2025

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription coverage offered under the employee group medical insurance with City of Sunrise and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **City of Sunrise has determined that the prescription drug coverage offered under the City of Sunrise's employee group medical insurance is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay, and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you have the right to keep your City of Sunrise prescription drug coverage under the employee group medical insurance and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your City of Sunrise's prescription coverage under the employee group medical coverage, be aware that you and your dependents may not be able to get this coverage back unless you are eligible to apply at the next City of Sunrise's employee group medical open enrollment. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with City of Sunrise and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

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

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

Contact Bill Mason at the City's Risk Management office for further information at (954) 838-4528. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if your prescription drug coverage through City of Sunrise changes from Creditable to Non-Creditable coverage status. You also may request a personalized copy of this same notice.

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

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

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

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

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

Date:	October 15, 2024
Name of Entity/Sender:	City of Sunrise
Contact--Position/Office:	Bill Mason, Risk Manager
Address:	10770 W Oakland Park Blvd, 4th Floor, Sunrise, FL 33351
Phone Number:	(954) 838-4528
Email:	riskmanagement@sunrisefl.gov

MEDICAL INSURANCE

AVMED HMO

AvMed Embrace better health® **City of Sunrise Large Group HMO**

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

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

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-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)	$200 copay/ visit	Not Covered	Prior authorization required.
	Physician/surgeon fees	No Charge	Not Covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	$200 copay/ visit	$200 copay/ visit	AvMed should be notified within 24-hours of impatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted.
	Emergency medical transportation	No Charge	No Charge	----------None----------
	Urgent care	$30 copay/ visit at urgent care facilities; $30 copay/ visit at retail clinics No charge for MDLive	$60 copay/ visit at urgent care facilities or retail clinics; Not Covered	----------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	No Charge	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 In-Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$15 copay/ visit	Not Covered	Limited to 60 skilled visits per calendar year. Approved treatment plan required.
	Rehabilitation services	$10 copay/ visit; $15 copay/ visit for chiropractic services	Not Covered	Limited to 60 visits per calendar year for rehabilitative physical, occupational and speech therapies combined; 18 visits per calendar year for cardiac rehabilitation. Cardiac rehabilitation requires prior authorization. Spinal manipulation is limited to 60 visits per calendar year.
	Habilitation services	No Charge	Not Covered	Limited to 100 visits per calendar year for habilitative physical, occupational, & speech therapies combined, when provided for the treatment of autism spectrum disorder and Down syndrome.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	No charge for DME supplied on an outpatient basis	Not Covered	Some limitations apply. Please see your Summary Plan Description for details.
	Hospice services	No Charge	Not Covered	Physician certification required.
If your child needs dental or eye care	Children's eye exam	$15 copay/ visit	Not Covered	Eye exam to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Children's dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information is: the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact AvMed's Member Engagement Center at 1-844-263-2369.

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.

About these Coverage Examples:

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

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

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

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

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

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

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

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

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

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

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

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Mia would pay is	$520

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

AVMED
POS

AvMed Embrace better health® **City of Sunrise Large Group POS**

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

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

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Prior authorization required.
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	AvMed should be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	----------None----------
	Urgent care	$30 copay/ visit at urgent care facilities; $30 copay/ visit at retail clinics No charge for MDLive	40% coinsurance after deductible; Not Covered	----------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	No Charge	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 In-Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 60 skilled visits per calendar year. Approved treatment plan required.
	Rehabilitation services	20% coinsurance after deductible; $30 copay/ visit for chiropractic services	40% coinsurance after deductible	Limited to 60 visits per calendar year for rehabilitative physical, speech & occupational therapies combined; 18 visits per calendar year for cardiac rehabilitation. Cardiac rehabilitation requires prior authorization. Limited to 60 visits per calendar year for Spinal Manipulation.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 100 visits per calendar year for habilitative physical, occupational and speech services combined, when provided for the treatment of autism spectrum disorder and Down syndrome.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 100 days post-hospitalization care per calendar year. Prior authorization required.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Some limitations apply. Please see your Summary Plan Description for details.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Physician certification required.
If your child needs dental or eye care	Children's eye exam	$10 copay/ visit	40% coinsurance after deductible	Eye exam to determine the need for sight correction.
	Children's glasses	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.
	Children's dental check-up	Not Covered	Not Covered	Not covered under this medical and pharmacy benefits plan.

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information is: the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800- 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact AvMed's Member Engagement Center at 1-844-263-2369.

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.

About these Coverage Examples:

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

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

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

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

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

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

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

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

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

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

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

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

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

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

AvMed

CITY OF SUNRISE FLORIDA

MDLIVE®

On-demand care for illness and injuries is part of your health plan.

MDLIVE. Anytime. Anywhere.

Getting sick is always a hassle. When you need care fast, talk to a board-certified MDLIVE doctor in minutes. Get reliable care from the comfort of home instead of an urgent care clinic or crowded ER. MDLIVE is open nights, weekends, and holidays. No surprise costs.

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Affordable alternative to urgent care clinics and the ER.
MDLIVE treats 80+ common conditions like flu, sinus infections, pink eye, ear pain, and UTIs (Females, 18+). By talking to a doctor at home, you can avoid long waits and exposure to other sick people.

Prescriptions.
Your MDLIVE doctor can order prescriptions[1] to the pharmacy of your choice. MDLIVE can also share notes with your local doctor upon request.

MDLIVE cares for more than 80 common, non-emergency conditions, including:

- Allergies
- Cold & Flu
- Cough
- Ear Pain
- Headache
- Prescriptions
- Pink Eye
- Sinus Problems
- Sore Throat
- UTI (Females, 18+)
- Yeast Infections
- And more

Your copay is $0 per appointment.

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[1]Prescriptions are available at the physician's discretion when medically necessary. A renewal of an existing prescription can also be provided when your regular physician is unavailable, depending on the type of medication.

Here are your remote Dedicated AvMed Client Service Representatives. Both real people, providing real customer service, and real solutions every time to your healthcare issues Monday through Friday 9 am – 5 pm regarding:

- Covered Services
- Pharmacy Benefits
- Co-Pays
- Provider Directories
- Provider Issues
- Network / Facilities
- Prior Authorizations
- Billing Questions
- Out of Area / PHCS Network
- Away From Home Program

Primary Dedicated Representative

Rosa Dawson, 305-671-4795 or rosa.dawson@avmed.org

Secondary Dedicated Representative

Mariagrazia Storaci, 352-316-7529 or mariagrazia.storaci@avmed.org

Our Client Service Representatives are dedicated to City of Sunrise employees and their dependents.

AvMed's City of Sunrise Member Engagement Center is also available at

1-844-263-2369 Monday through Friday, 8 am – 8 pm and Saturday, 9 am – 1 pm

"Providing you with benefit plans, not torture plans – Risk Management"

DENTAL INSURANCE

METLIFE HMO

MetLife

SCHEDULE OF BENEFITS

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

Direct Referral Dental Plan SGCM1029

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

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

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

Code	Service	Co-payment
	Diagnostic Treatment	
D0120	Periodic oral evaluation - established patient. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient. Report additional diagnostic procedures separately.t	$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. This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history, and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships.	$0
•	Office visit - per visit (including all fees for sterilization and/or infection control)	$5
	Radiographs/Diagnostic Imaging (X-rays)	
D0210	A radiographic survey of the whole mouth, usually consisting of 14-22	$0

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	periapical and posterior bitewing images intended to display the crowns and roots of all.	
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
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
D0372	A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. Comprehensive series of radiographic images.	$0
D0373	Intraoral tomosynthesis- bitewing radiographic image	$0
D0374	Intraoral tomosynthesis – periapical radiographic image	$0
D0396	3D printing of a 3D dental surface scan	$0
	Tests and Examinations	
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Laboratory accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0
	Preventive Services	
D1110	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

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
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
D1557	Removal of fixed bilateral space maintainer - maxillary	$15
D1558	Removal of fixed bilateral space maintainer - mandibular	$15
	Restorative Treatment	
D2140	Amalgam – one surface, primary or permanent	$0
D2150	Amalgam – two surfaces, primary or permanent	$0
D2160	Amalgam – three surfaces, primary or permanent	$0
D2161	Amalgam – four or more surfaces, primary or permanent	$0
D2330	Resin-based composite – one surface, anterior	$0
D2331	Resin-based composite – two surfaces, anterior	$0
D2332	Resin-based composite – three surfaces, anterior	$0
D2335	Resin-based composite – four or more surfaces (anterior)	$0
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite – one surface, posterior	$30
D2392	Resin-based composite – two surfaces, posterior	$45
D2393	Resin-based composite – three surfaces, posterior	$65
D2394	Resin-based composite – four or more surfaces, posterior	$65
	Crowns	
	• *An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a $75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.*	
	• *Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.*	
D2510	Inlay – metallic – one surface	$225
D2520	Inlay – metallic – two surfaces	$235
D2530	Inlay – metallic – three or more surfaces	$245
D2542	Onlay – metallic – two surfaces	$245
D2543	Onlay – metallic – three surfaces	$260
D2544	Onlay – metallic – four or more surfaces	$270

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D2610	Inlay – porcelain/ceramic – one surface	$245
D2620	Inlay – porcelain/ceramic – two surfaces	$245
D2630	Inlay – porcelain/ceramic – three or more surfaces	$245
D2642	Onlay – porcelain/ceramic – two surfaces	$245
D2643	Onlay – porcelain/ceramic – three surfaces	$245
D2644	Onlay – porcelain/ceramic – four or more surfaces	$245
D2650	Inlay – resin-based composite – one surface	$245
D2651	Inlay – resin-based composite – two surfaces	$245
D2652	Inlay – resin-based composite – three or more surfaces	$245
D2662	Onlay – resin-based composite – two surfaces	$245
D2663	Onlay – resin-based composite – three surfaces	$245
D2664	Onlay – resin-based composite – four or more surfaces	$245
D2710	Crown – resin-based composite (indirect)	$245
D2712	Crown – ¾ resin-based composite (indirect)	$245
D2720	Crown – resin with high noble metal	$245
D2721	Crown – resin with predominantly base metal	$245
D2722	Crown – resin with noble metal	$245
D2740	Crown - porcelain/ceramic	$245
D2750	Crown – porcelain fused to high noble metal	$245
D2751	Crown – porcelain fused to predominantly base metal	$245
D2752	Crown – porcelain fused to noble metal	$245
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	Interim crown – further treatment or completion of diagnosis necessary prior to final impression. Further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary crown for a routine prosthetic restoration.	$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

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
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 customize a crown to fit under an existing partial denture framework. This procedure is in addition to the separate a crown procedure documented with its own code.	$50
D2976	Band stabilization – per tooth	$7
D2980	Crown repair necessitated by restorative material failure	$0
D2989	Excavation of a tooth resulting in the determination of non-restorability	$0
	Endodontics	
	All procedures exclude final restoration.	
D3110	Pulp cap – direct (excluding final restoration)	$5
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$25
D3221	Pulpal debridement, primary and permanent teeth	$55
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$40
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$40
D3310	Anterior (excluding final restoration)	$100
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$152
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$210
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$96
D3333	Internal root repair of perforation defects: Non-surgical seal of perforation caused by resorption and/or decay but not iatrogenic by same provider.	$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

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
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
	Periodontics	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	$100
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	$60
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant: A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth or fractured root. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.	$150
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant: A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth or fractured root. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.	$113
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening – hard tissue	$150
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	$300
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	$180
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$180
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site. Biologic materials may be used alone or with other regenerative substrates such as bone and barrier membranes, depending upon their formulation and the presentation of the periodontal defect. This procedure does not include surgical entry and closure, wound debridement, osseous contouring, or the placement of graft materials and/or barrier membranes. Other separate procedures may be required concurrent to D4265 and should be reported using their own unique codes.	$95
D4266	Guided tissue regeneration, natural teeth – resorbable barrier, per site: This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of	$215

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.	
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site: This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.	$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
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	$50
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns	$50
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 periodontal evaluation and diagnosis on a subsequent visit.	$50
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$65
D4910	Periodontal maintenance (2 in a 12 month period)	$40
D4999	Unspecified periodontal procedure, by report Periodontal charting for planning treatment of periodontal disease	$0
•	Unspecified periodontal procedure, by report Periodontal hygiene instruction	$0
	Removable Prosthodontics	
•	*Includes up to 3 adjustments within 6 months of delivery.*	
D5110	Complete denture – maxillary	$325
D5120	Complete denture – mandibular	$325
D5130	Immediate denture – maxillary	$350
D5140	Immediate denture – mandibular	$350
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$400
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$400
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including 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

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D5222	Immediate mandibular 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
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
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth	$400
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth	$400
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
D5725	Rebase hybrid prosthesis	$75
D5730	Reline complete maxillary denture (chairside)	$60

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
D5731	Reline complete mandibular denture (chairside)	$60
D5740	Reline maxillary partial denture (chairside)	$60
D5741	Reline mandibular partial denture (chairside)	$60
D5750	Reline complete maxillary denture (laboratory)	$85
D5751	Reline complete mandibular denture (laboratory)	$85
D5760	Reline maxillary partial denture (laboratory)	$85
D5761	Reline mandibular partial denture (laboratory)	$85
D5765	Soft liner for complete or partial removable denture – indirect	$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. Each pair of components is one precision attachment. Describe the type of attachment used.	$150
D6089	Accessing and retorquing loose implant screw – per screw	$0
D6106	Guided tissue regeneration – resorbable barrier, per implant. This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	$215
D6107	Guided tissue regeneration – non-resorbable barrier, per implant. This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	$255
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.	$30
	Crowns/Fixed Bridges - Per Unit	
	• *An additional charge will be applied for any procedure using noble or high noble metal.*	
	• *Cases involving 7 or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.*	
D6210	Pontic – cast high noble metal	$245
D6211	Pontic – cast predominantly base metal	$245
D6212	Pontic – cast noble metal	$245
D6214	Pontic – titanium 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	Further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary pontic for a routine prosthetic	$0

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	restoration.	
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$150
D6600	Retainer inlay – porcelain/ceramic, two surfaces	$245
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	$245
D6602	Retainer inlay – cast high noble metal, two surfaces	$245
D6603	Retainer inlay – cast high noble metal, three or more surfaces	$245
D6604	Retainer inlay – cast predominantly base metal, two surfaces	$245
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	$245
D6606	Retainer inlay – cast noble metal, two surfaces	$245
D6607	Retainer inlay – cast noble metal, three or more surfaces	$245
D6608	Retainer onlay – porcelain/ceramic, two surfaces	$245
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	$245
D6610	Retainer onlay – cast high noble metal, two surfaces	$245
D6611	Retainer onlay – cast high noble metal, three or more surfaces	$245
D6612	Retainer onlay – cast predominantly base metal, two surfaces	$245
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	$245
D6614	Retainer onlay – cast noble metal, two surfaces	$245
D6615	Retainer onlay – cast noble metal, three or more surfaces	$245
D6710	Retainer crown – indirect resin based composite	$245
D6720	Retainer crown – resin with high noble metal	$245
D6721	Retainer crown – resin with predominantly base metal	$245
D6722	Retainer crown – resin with noble metal	$245
D6740	Retainer crown – porcelain/ceramic	$245
D6750	Retainer crown – porcelain fused to high noble metal	$245
D6751	Retainer crown – porcelain fused to predominantly base metal	$245
D6752	Retainer crown – porcelain fused to noble metal	$245
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. A pair of components constitutes one precision attachment, that is separate from the prosthesis.	$150
D6980	Fixed partial denture repair necessitated by restorative material failure	$45
	Oral Surgery	
	• *Includes routine post operative visits/treatment.*	
	• *The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.*	
D7111	Extraction, coronal remnants – primary tooth	$5

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
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 spaces, per quadrant	$40
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$15
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$45
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$25
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$25
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$35
D7520	Incision and drainage of abscess – extraoral soft tissue	$35
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$35
D7910	Suture of recent small wounds up to 5 cm	$25
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

Orthodontics

- *Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.*
- *Comprehensive orthodontic benefits include all phases of treatment and*

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
	fixed/removable appliances.	
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
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 and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250
•	Unspecified orthodontic procedure, by report Ortho visits beyond 24 months of active treatment or retention	$25 per visit
	Adjunctive General Services	
D9110	Palliative treatment of dental pain per visit: Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes. This is typically reported on a “per-visit” basis for emergency treatment of dental pain.	$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, subsequent to detailed and extensive treatment planning.	$0
D9610	Therapeutic parenteral drug, single administration	$15
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$25

SCHEDULE OF BENEFITS (CONTINUED)

Code	Service	Co-payment
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
D9954	Fabrications and delivery of oral appliance therapy (OAT) morning repositioning device	$16
D9955	Oral appliance therapy (OAT) titration visit	$10
D9972	External bleaching – per arch - performed in office	$125
D9986	Missed appointment (less than 24-hr notice)	Not to exceed $25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0
D9999	Unspecified adjuctive procedure, by report	

Dental Terminology Definitions

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

Amalgam: A silver filling

Anterior: Teeth that are in the front of the mouth

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

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

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

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

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

Exclusions and Limitations

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

Exclusions and Limitations

Limitations

General

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

Preventive

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

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

Diagnostic

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

Restorative

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

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

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

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

Prosthodontics

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

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

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

Endodontics

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

Oral Surgery

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

Exclusions and Limitations

General Exclusions

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

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

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

4. Orthognathic surgery.

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

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

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

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

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

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

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

12. Dental services considered experimental in nature.

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

Exclusions and Limitations

Orthodontic Exclusions and Limitations

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

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

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

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

5. The following are not included as orthodontic benefits:

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

b). Retreatment of orthodontic cases;

c). Treatment involving:

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

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

3). Treatment related to temporomandibular joint disorders;

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

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

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

METLIFE

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&
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Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

City of Sunrise

Network: PDP Plus

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

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

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
[2]Negotiated fees refer 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.

[3]Your plan includes incentive provisions. Deductibles, plan maximums and/or co-insurance percentages may differ by plan member.
*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.
*** Orthodontia excluded for adults. Available for dependent children up to age 26.

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: PDP Plan How Many/How Often	Plan Option 2: High PDP Plan How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	One per 6 months	One per 6 months
Oral Examinations	One exam per 6 months	One exam per 6 months

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

City of Sunrise

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	• Bitewings X-rays; one set per 12 months	• Bitewings X-rays; one set per 12 months
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday, once per tooth area per lifetime	Space maintainers 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
Type B — Basic Restorative		
Fillings	Once per surface per every 12 months	Once per surface per every 12 months
Simple Extractions		
X-rays	Full mouth X-rays; one per 60 months	Full mouth X-rays; one per 60 months
Endodontics	N/A	Root canal treatment limited to once per tooth per 24 months
Periodontics	• N/A	• Periodontal scaling and root planing once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed one treatment per 6 months
Type C — Major Restorative		
Crown, Denture and Bridge Repair/ Recementations		
Oral Surgery		
Implants	N/A	Replacement once every 84 months
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 84 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 84 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	Replacement once every 84 months	Replacement once every 84 months
Endodontics	Root canal treatment limited to once per tooth per 24 months	N/A

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

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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	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed one treatments in a six month period	• Periodontal surgery once per quadrant, every 36 months
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 • 25% of the Orthodontia Lifetime Maximum amount charged by the will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary • Orthodontic benefits end at cancellation of coverage	• Your children, up to age 26, are covered while Dental insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis • 25% of the Orthodontia Lifetime Maximum amount charged by the 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;

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

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- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal (Low Plan only);
- Repair of implants (Low Plan only);
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth (High Plan only);
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders;
- 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, payment 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 payment for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

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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 participation ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 90 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

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.†

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 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 Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern. 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, or call 1-866-PDP-NTWK for an application.†† 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 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 $500. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

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?

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

City of Sunrise

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.

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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. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY.

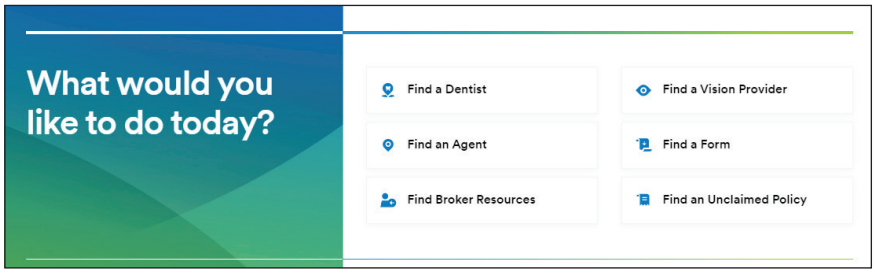
MetLife | Dental Insurance

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.

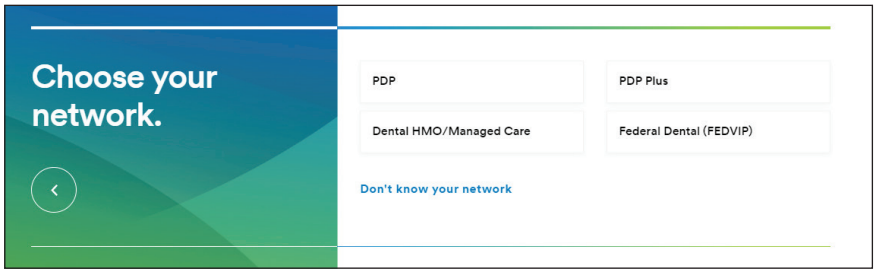
Step 1:
Go to metlife.com

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.



8

VISION INSURANCE

Low Vision Plan

Humana Vision

FLORIDA
Low Plan

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	Up to $150 20% off balance over $150	Up to $65
Standard plastic lenses[4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90, 80% of charge, then up to $120	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	Up to $150, 15% off balance over $150	Up to $104
• Disposable	Up to $150	Up to $104
• Medically necessary	$0	Up to $200

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Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] 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.
[3] Discounts available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] 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 anesthetist.
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.[1]

[1] Thompson Media Inc.

Questions?

Check out 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.

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High Vision Plan

Humana Vision 130

City of Sunrise

FLORIDA

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $40	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$250 allowance 20% off balance over $250	$65 allowance
Standard plastic lenses[4]		
• Single vision	$10	Up to $25
• Bifocal	$10	Up to $40
• Trifocal	$10	Up to $60
• Lenticular	$10	Up to $100
Lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$10	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] **(applies to materials only)**		
• Conventional	$250 allowance, 15% off balance over $250	$104 allowance
• Disposable	$250 allowance	$104 allowance
• Medically necessary	$0	$200 allowance

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 12 months	Once every 12 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33
Optional benefits		
• 12-month Frame Benefit	Benefit replaces the 24-month frequency of the base plan.	

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] 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.
[3] Discounts available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or frames, but not both.

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.

Vision health impacts overall health

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

[1] Thompson Media Inc.

Questions?

Check out **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.

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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 anesthetist.
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.

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. In Arizona, group vision plans insured by Humana Insurance Company. In New Mexico, group vision plans insured by Humana Insurance Company.

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.

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, gender identity, ancestry, ethnicity, marital status, religion, or language. 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 **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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 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. 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 resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
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): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

LIFE INSURANCE

7e

Standard Insurance Company **Beneficiary Designation/Change**

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

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

MEMBER/EMPLOYEE INFORMATION

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

BENEFICIARY INFORMATION

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

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

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

Signature of Member/Employee _____ Date _____

Risk Management Department - *Retain for your records.*

AFLAC INSURANCE

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

or

Kimberly H. Finley, Benefit Consultant
AFLAC – Florida Southeast
Tel: 954.320.6016
Fax: 954.474.4305 | Mobile: 954.320.7551
kim@fsgsfl.com

AFLAC – SOUTHEAST | Framework Solutions Group
2598 E. Sunrise Blvd., Suite 2104
Fort Lauderdale, FL 33304

9a

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.

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B70175FL

IC(10/18)

Coverage Options

Choose the Policy and Riders that Fit Your Needs

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

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

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

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

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

Aflac

Cancer Protection Assurance

CANCER INDEMNITY INSURANCE – OPTION 2

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

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

Aflac SmartClaim®
One Day Pay™

Coverage Options

Choose the Policy and Riders that Fit Your Needs

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

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

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

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

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

Aflac Accident Advantage

ACCIDENT-ONLY INSURANCE – OPTION 2

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

Aflac SmartClaim®
One Day Pay℠

AFLAC ACCIDENT ADVANTAGE

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

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

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

ACCIDENTAL-DEATH BENEFIT

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

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

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

Aflac Accident Advantage

ACCIDENT-ONLY INSURANCE – OPTION 3

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AFLAC ACCIDENT ADVANTAGE

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

ACCIDENTAL-DEATH BENEFIT

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

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

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

Aflac Critical Care Protection

SPECIFIED HEALTH EVENT INSURANCE – OPTION 1

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

Aflac®

Aflac Critical Care Protection – Option 1 Benefit Overview

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

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

Aflac Critical Care Protection

SPECIFIED HEALTH EVENT INSURANCE – OPTION 2

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

Aflac

Aflac Critical Care Protection – Option 2 Benefit Overview

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

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

OPTIONAL FIRST-OCCURRENCE BUILDING BENEFIT

RIDER SUMMARY PAGE

Policy Rider Series A74000

CCP®

PEACE OF MIND. CASH BENEFITS.

OUR INSURANCE POLICIES HELP PROVIDE BOTH.

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

WHAT WE WILL PAY

FIRST-OCCURRENCE BENEFIT

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

DEFINITIONS

EFFECTIVE DATE

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

TERMINATION

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

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

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

Aflac

Aflac
Short-Term Disability Insurance

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

Aflac®

Understand the difference Aflac makes in your financial security.

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

Coverage Options

Choose the Policy You Need

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

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

*Subject to certain conditions/maximum.

How it works

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

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

9b

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

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City of Sunrise

Florida Payroll Premium rates are Biweekly for industry Class A.

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CANCER PROTECTION ASSURANCE PLAN LEVEL 1 - Series B70100

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

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

CANCER PROTECTION ASSURANCE PLAN LEVEL 2 - Series B70200

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

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

CRITICAL CARE PROTECTION POLICY - Series A74100

Individual

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

One Parent Family

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

Insured/Spouse

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

Two Parent Family

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

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

CRITICAL CARE PROTECTION POLICY - Series A74200

Individual

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

One Parent Family

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

Insured/Spouse

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

Two Parent Family

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

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

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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
☐ Enrollment ☐ Discontinue Coverage				
☐ Change Coverage ☐ Open Enrollment				

PLANS	Tyler Munis Codes	Prior Deduction Pre-Tax	Prior Deduction Post-Tax	New Deduction Pre-Tax	New Deduction 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.

EMPLOYEE SIGNATURE

DATE

APPROVAL/DATE SENT TO PAYROLL
(Risk Use Only)

HTE ENTERED DATE
(Payroll Use Only)