



2020

Group Insurance Information

Revised October 15, 2019



Important Contact Information

Palm Beach County Board of County Commissioners (BCC):

Risk Management/Group Insurance

100 Australian Avenue, Suite 200, West Palm Beach, FL 33406

Telephone: (561) 233-5400 ♦ Fax: (561) 242-7184 ♦ Email: BCCMyBenefits@pbcgov.org

Website: www.pbcgov.org/mybenefits

Palm Tran

Human Resources Department

3201 Electronics Way, West Palm Beach, FL 33407

Telephone: (561) 841-4237 ♦ Fax: (561) 841-4283 ♦ Email: Pthr@pbcgov.org

Palm Beach County Supervisor of Elections

240 S. Military Trail, West Palm Beach, FL 33415

Telephone: (561) 656-6272 ♦ Fax: (561) 656-6282

Online Benefits System for BCC and Palm Tran Employees: MyBenefits

www.pbcgov.org/mybenefits

Insurance Carriers/Vendors

Benefit/Provider	Customer Service	Group Policy #
Medical: CIGNA Healthcare - www.mycigna.com On-site Cigna customer service representatives: Jacquelyn Ebert: Jacquelyn.Ebert@Cigna.com Peggy Lacroix: Peggy.Lacroix@Cigna.com Cigna Home Delivery Prescription Program	1-800-CIGNA-24/ 1-800-244-6224 1-561-233-5463 1-561-233-5474 1-800-835-3784	3212040
Dental: Solstice Benefits, Inc. www.solsticebenefits.com or www.MySolstice.net	1-855-494-0098 pbcgov@solsticebenefits.com	13000
Life Insurance: Securian Financial Insurance Co. www.lifebenefits.com	1- 866-293-6047	33696
Short and Long term Disability: CIGNA Group Insurance www.cigna.com - Short-Term Disability - Long-Term Disability	1-800-732-1603 <i>Report a claim:</i> 800-362-4462 800-642-8553 (Fax) <i>To file a claim online:</i> Click on <u>Forms</u> located in the <u>Customer Care</u> tab	LTD: FLK-960504 STD: VDT-960736
Flexible Spending Accts: P&A Group www.padmin.com	1-800-688-2611	
CIGNA Vision Plan (part of MEDICAL) www.vsp.com	1-877-478-7557	3212040
Clear 100 Vision Plan (part of DENTAL – available in specific counties in FLORIDA only) www.SolsticeBenefits.com	Call number on back of your dental ID card 1-855-494-0098	13000
Employee Assistant Program/EAP	1-561-233-5460	

This booklet is a summary of plan provisions related to the various Group Insurance policies issues. In the event of a conflict between this summary and the applicable Group Insurance policy and/or certificate, the policy and/or certificate shall dictate the insurance and coverage provisions, exclusions, all limitations and terms of coverage. In accordance with the provisions of ADA, this document may be requested in an alternative format. If you have any questions or would like to receive additional benefit plan materials, please contact your Group Insurance office or representative.

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Introduction

Palm Beach County and its subsidiaries offer a wide range of benefits to their benefit-eligible employees. This guide provides a general summary of group insurance plans approved by the Palm Beach County Board of County Commissioners. They are medical (with pharmacy included), dental, vision care services included in medical and dental plans, life, short-term and long-term disability insurance and flexible spending account programs.

This guide will describe the programs in the County's Group Insurance Benefits Plan that are made available to eligible employees of:

- a. Palm Beach County Board of County Commissioners (BCC)
- b. Supervisor of Elections
- c. Palm Tran, Inc.

If you have any questions regarding your group insurance benefits, please contact your respective group insurance office or representative as follows:

- a. Palm Beach County Board of County Commissioners
Risk Management/Group Insurance Department
100 Australian Avenue, Suite 200
West Palm Beach, FL 33406
Telephone: (561) 233-5400 Fax: (561) 242-7184 Email: BCCMyBenefits@pbcgov.org
- b. Supervisor of Elections
Palm Beach County Supervisor of Elections Office
240 S. Military Trail
West Palm Beach, FL 33415
Telephone: (561) 656-6272 Fax: (561) 656-6282
- c. Palm Tran, Inc.
Human Resources Department
3201 Electronics Way
West Palm Beach, FL 33407
Telephone: (561) 841-4237 Fax: (561) 841-4283 Email: Pthr@pbcgov.org

Palm Beach County and each of the above agencies separately provide a comprehensive compensation and benefits package including, retirement plans, holidays, vacation and sick leave. Please refer to each agency's administrative offices for detailed descriptions and stipulations of all benefits available to employees.

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.pbcgov.org/mybenefits. A paper copy is also available, free of charge by calling 561-233-5400. A Glossary is available on MyBenefits or can be requested by calling 561-233-5400 or email: BCCMyBenefits@pbcgov.org

Palm Beach County Employee Wellness Program



The mission of the program is to establish, promote, and support programming that fosters positive physical and mental wellbeing through wellness education, activities, and opportunities both within and outside the workplace for employees and their families.

Annual Healthy Family Fun! A free 5K Fun Run/Walk is hosted in January for employees and their benefits-eligible spouses/dependents.	Get Active! All fitness classes are free and hosted at local Parks & Recreation facilities. Group classes are offered every week, year-round and include Zumba, Yoga, Pilates, Cardio Kickboxing, Aqua-Fit, walking groups, and more. All BCC employees and their Cigna-insured dependents (ages 14+) may attend.
Extra \$\$\$ in your wallet! Participate in certain wellness activities and earn wellness incentive rewards. *For Cigna-insured employees.	Live Healthy! Scheduled lunchtime and evening educational seminars cover topics such as healthy eating, weight loss, stress management, meditation, smoking cessation, etc. Discounts for the Weight Watchers at Work program is also available for Cigna-insured employees.

For more information on Wellness Program offerings and to obtain a current schedule of events, contact Joanna Matwiejczuk, Wellness Program Coordinator at wellness@pbcgov.org or (561) 233-5451.

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Enrollment Guide for New Employees

QUESTION:	ANSWER:
When will my Group Insurance coverage become effective?	Your Group Insurance coverage will become effective the first of the month following or coinciding with 60 days of employment. For example, if your date of hire is May 15 th , your group insurance benefits will be effective August 1 st .
How do I sign up for Group Insurance Benefits?	You elect your Group Insurance benefits through your benefits enrollment system, MyBenefits .
What website do I go to for MyBenefits?	The website is: www.pbcgov.org/mybenefits
When can I sign up for my Group Insurance benefits?	Starting on your 15 th calendar day of employment and ending on your 31 st calendar day of employment. Following your first two weeks of acclimation on the job, you will receive an e-mail in week three of your employment advising you that you are now able to access MyBenefits website
I don't have access to e-mail. How will I know when I am able to log on	Your supervisor will be copied on the e-mail to you, advising him or her that your access to MyBenefits is available.
Where can I access the website?	You can access the website from home or work either by entering the address listed above; or from work by clicking on the MyBenefits link on the Palm Beach County home page.
What hours can I access the website?	Once the system is available you may access it 24 hours a day, seven days per week during your new hire election period.
What do I need to sign in to MyBenefits?	You need to use the network User ID and Password you have been assigned as a new hire and which you would also use to, for example, to access HRIS for your paycheck information. <u>Note:</u> It takes 24 hours for you to be able to use your network user ID and password, once issued.
What if I'm unsure of my County network User ID?	Contact the Help Desk at 561-355-HELP during normal business hours.
Who can I contact if I don't have my User ID or Password or are unable to sign in?	Contact the Information Systems Services department at 561-355-HELP (4357) during normal business hours.
What else do I need to know about using the system?	For security reasons you will be automatically logged out after 15 minutes of inactivity. You can hit any key to reset the clock during an active session.
Do I have to elect benefits for myself in order to add my dependents?	Yes, you do. In order to cover your dependents for health and dental you first must elect coverage for yourself.

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What type of documents do I need to provide after I elect my group insurance benefits?	If applicable, you must forward the following documents to your Group Insurance Office: Dependent Verification documentation - (please refer to the Eligibility Document section of this guidebook for applicable dependent eligibility information). All required dependent documentation MUST be received in your Group Insurance office within 60 calendar days of your date of hire. Your dependents will not be enrolled in the plans that you have elected for them, if the required information is not received. Such dependents will not be eligible for coverage until the next applicable Open Enrollment period, except in the case of a qualifying event. Proof of current medical coverage under another plan – is required if you decline/waive medical coverage in MyBenefits, and you are eligible for the Opt-Out Benefit and the proof MUST clearly include your name as an insured. Please note if you are qualified for Opt-Out benefits, but fail to submit the documentation above to your Group Insurance office, you will not be enrolled in the Opt-Out benefit.
What other documents will I have to process?	Evidence of Insurability: - For additional life coverage greater than \$150,000 - For spousal/domestic partner life coverage greater than \$25,000 You/your spouse or domestic partner will have to successfully complete medical underwriting for coverage in excess of the guaranteed issue amount. Your Group Insurance office will issue the Evidence of Insurability form to you. Once you receive it please forward the form to Securian Financial as soon as possible. If the form is not received, Securian Financial will be unable to proceed with the medical underwriting process and coverage in excess of any guaranteed issue amount will not be considered for approval. Please contact Securian Financial at 1-800-872-2214 with any questions regarding the Evidence of Insurability process.
What happens if I do not elect benefits within the first 31 days of my date of hire? IMPORTANT -	If you do not elect benefits via MyBenefits during the first 31 calendar days of your employment, you will be automatically enrolled in: - Medical coverage: CIGNA HMO* (Employee Only coverage) – see premium information in the Employee Benefits Information guide - Disability coverage: CIGNA Core - free basic LTD plan - Life Insurance coverage: Securian Financial free basic term life coverage of \$25,000 & free basic \$15,000 AD&D Default benefits insure the employee only and will not cover any dependents. Therefore, it is important if you wish to enroll your qualified dependents and/or select coverage other than what is outlined under default benefits, that you make an active election via MyBenefits within the allowable 31 calendar day window, from your date of hire. Failure to make an active election within the allowable 31 calendar day window will result in your dependents not being able to enroll in coverage until the next applicable open enrollment period, or within 30 calendar days of a qualified family status change. Additionally, you cannot make a change to default benefits (e.g. elect Cigna POS medical coverage, elect dental coverage, etc.) after your election period has passed and prior to any future Open Enrollment period or following a qualified family status change.

	In addition, for any plans that have guaranteed issue benefits (short-term and long-term disability, additional life, and spouse/domestic partner life) and which are not elected when you first become eligible you/ your spouse or domestic partner will lose the guaranteed issue benefit and must successfully complete the Evidence of Insurability process as outlined in the respective group insurance plan documents to be qualified for the benefit. Check your group insurance benefits premium deductions every pay day; any discrepancies must be brought to the attention of your Group Insurance office IMMEDIATELY.
How do I elect my Primary Care Physician (PCP) for the Cigna medical HMO or POS coverage?	If you are actively electing your new hire benefits via MyBenefits make sure to elect a PCP for yourself and any of your enrolled dependents at the time of your enrollment. If you are assigned default medical benefits, please contact the Cigna Onsite Service Representatives to elect your Primary Care Physician (PCP) prior to your coverage effective date: Monica Kates Tel: 561-233-5463 e-mail: Monica.Kates@cigna.com Peggy Lacroix Tel: 561-233-5474 e-mail: Peggy.Lacroix@cigna.com Alternatively, you can also contact Cigna at 1-800-CIGNA24 (1-800-244-6224) 24 hours a day/365 days a year for assistance with this process. Please be aware that if you do not select a PCP for the HMO plan or POS plan, Cigna will automatically assign one which may not be your physician of choice; this could cause you and your dependents a delay in medical care or obtaining any necessary referrals.
When do I start paying for my Group Insurance benefits?	Deductions will start with the pay period that contains your coverage begin date. It's typically the first and no later than the second check within the month your coverage becomes effective
Resources	Contact your Group Insurance office for any assistance with your benefits enrollment/questions: BCC Employees: Risk Management/Group Insurance – 561-233-5400 Email: BCCMyBenefits@pbcgov.org Palm Tran Employees: Palm Tran/Human Resources Department - 561-841-4237 Email: Pthr@pbcgov.org Supervisor of Election Employees: Contact 561-656-6272 Contact the Cigna Onsite Service Representatives for benefit information including summary plan descriptions, provider information, plan documents, compliance notices and retail pharmacy program information are available on MyBenefits or the Risk Management/Group Insurance department website Monica Kates Tel: 561-233-5463 e-mail: Monica.Kates@cigna.com Peggy Lacroix Tel: 561-233-5474 e-mail: Peggy.Lacroix@cigna.com

Benefits Rates

Medical Insurance – CIGNA – The County shares the cost of the premium with employee

Plan	Level of coverage	Actual Cost	Monthly Employer Portion	Biweekly Employer Portion	Monthly Employee Portion	Biweekly Employee Portion
HMO	EE Only	\$794.28	\$763.28	\$381.64	\$31.00	\$15.50
	EE + 1	\$1,653.14	\$1,452.14	\$726.07	\$201.00	\$100.50
	EE+ 2 or more	\$2,268.30	\$1,928.30	\$964.15	\$340.00	\$170.00
	Overage Dep.*	\$476.56	\$0.00	\$0.00	\$476.56	\$238.28
OAPIN	EE Only	\$830.02	\$781.02	\$390.51	\$49.00	\$24.50
	EE + 1	\$1,727.54	\$1,452.54	\$726.27	\$275.00	\$137.50
	EE+ 2 or more	\$2,370.38	\$1,928.30	\$964.19	\$442.00	\$221.00
	Overage Dep.*	\$498.00	\$0.00	\$0.00	\$498.00	\$249.00
POS	EE Only	\$880.96	\$813.96	\$406.98	\$67.00	\$33.50
	EE + 1	\$1,808.38	\$1,480.38	\$740.19	\$328.00	\$164.00
	EE+ 2 or more	\$2,482.26	\$1,981.26	\$990.63	\$501.00	\$250.50
	Overage Dep.*	\$545.60	\$0.00	\$0.00	\$545.60	\$272.80
*Overage Dependent: Additional amounts for each dep. age 26– 30 will be added to rates for other levels of coverage and 100% employee paid on a post-tax basis						

Dental Insurance –Solstice – Premiums are 100% employee paid

Plans	Solstice DHMO		Solstice Low PPO		Solstice High PPO	
Level of Coverage	Actual Monthly Cost	Biweekly Deduction	Actual Monthly Cost	Biweekly Deduction	Actual Monthly Cost	Biweekly Deduction
EE Only	\$11.16	\$5.58	\$17.21	\$8.61	\$32.33	\$16.17
EE + 1	\$19.09	\$9.55	\$32.67	\$16.34	\$61.95	\$30.98
EE+ 2	\$25.87	\$12.94	\$39.96	\$19.98	\$71.57	\$35.79
EE+ 3 or more	\$34.13	\$17.07	\$55.49	\$27.75	\$101.22	\$50.61

Term Life & AD&D Insurance – Securian Financial Insurance Co.

- Free Basic Term Life: EE Only - \$25,000 + \$15,000 AD&D coverage - 100% employer paid - Additional/Supplement Life & AD&D – EE Only - \$10,000 increments up to \$300,000. 100% employee paid							
Coverage Amount	Bi-weekly Rate		Coverage Amount	Bi-weekly Rate		Coverage Amount	Bi-Weekly Rate
\$10,000	\$1.68		\$110,000	\$18.48		\$210,000	\$35.28
\$20,000	\$3.36		\$120,000	\$20.16		\$220,000	\$36.96
\$30,000	\$5.04		\$130,000	\$21.84		\$230,000	\$38.64
\$40,000	\$6.72		\$140,000	\$23.52		\$240,000	\$40.32
\$50,000	\$8.40		\$150,000	\$25.20		\$250,000	\$42.00
\$60,000	\$10.08		\$160,000	\$26.88		\$260,000	\$43.68
\$70,000	\$11.76		\$170,000	\$28.56		\$270,000	\$45.36
\$80,000	\$13.44		\$180,000	\$30.24		\$280,000	\$47.04
\$90,000	\$15.12		\$190,000	\$31.92		\$290,000	\$48.72
\$100,000	\$16.80		\$200,000	\$33.60		\$300,000	\$50.40
- Spouse Term Life and AD&D Insurance – \$5,000 increments up to \$50,000 not to exceed 100% of employee's total coverage. - Child Term Life Insurance – \$5,000 or \$10,000 coverage.							

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SPOUSE Coverage Amount	Bi-weekly Rate		SPOUSE Coverage Amount	Bi-weekly Rate		CHILD Coverage Amount	Bi-weekly Rate
\$5,000	\$0.84		\$30,000	\$5.04		\$5,000	\$0.17
\$10,000	\$1.68		\$35,000	\$5.88		\$10,000	\$0.34
\$15,000	\$2.52		\$40,000	\$6.72			
\$20,000	\$3.36		\$45,000	\$7.56		*100% employee paid	
\$25,000	\$4.20		\$50,000	\$8.40			

Short Term Disability Insurance – CIGNA Group Insurance

EE Only - Weekly benefit is 67% of gross/max \$1200/week. **100% employee paid**
\$15.75 - Bi-weekly Rate

Long Term Disability Insurance – CIGNA Group Insurance

Free Basic LTD – EE Only – must have the HMO or OAPIN medical plan. Monthly benefit is 50% of monthly gross/max \$1,000/month. ***100% Employer paid.**

Voluntary /Buy-Up LTD – EE Only - Monthly benefit is 60% of monthly gross / max \$5,000/month.

100% employee paid. Cost is based on salary. Use formula to calculate rate:

- Employee with HMO/OAPIN: Annual salary ÷ 12 months x .0045 = monthly ÷ 2 = bi-weekly rate
- Employee without HMO/OAPIN: Annual salary ÷ 12 months x .0058 = monthly ÷ 2 = bi-weekly rate

Example: HMO/OAPIN EE @ \$30,000/yr will pay \$3.33 bi-weekly ♦Non-HMO/OAPIN EE @ \$30,000 will pay \$7.25 bi-weekly

FLEXIBLE SPENDING ACCOUNTS – P & A Administrative Services, Inc.

Contributions are based on 26 pay periods

- Healthcare FSA contributions: \$260 min - \$2,700 max annually or \$10.00 - \$103.85 bi-weekly
- Dependent Care FSA contributions: \$260 min - \$5,000 max annually or \$10.00 min – \$ 192.31 bi-weekly

- All Rates are subject to change.
- The same rates apply for medical, dental and life coverage that include domestic partner. However, the costs for the domestic partner/eligible domestic partner dependent will be deducted on a post-tax basis

The County's Group Insurance Plans

Each year the Board of County Commissioners evaluates, selects and approves benefit options that will be offered to employees for the following plan year. The County's Group Insurance Plan year is January 1st through December 31st. Currently, the County offers the following insurance plans through various carriers:

- Medical Insurance - CIGNA
- Dental Insurance - Solstice Benefits, Inc.
- Term life Insurance - Securian Financial
- Short-Term Disability - CIGNA
- Long-term Disability - CIGNA
- Flexible Spending Accounts program - P&A Group
- Additionally, the County offers a benefit incentive for qualified employees who decline medical insurance or “opt-out” of the Group's medical plan because they are otherwise covered under another qualified medical plan.

Plan Documents, Contracts and Publications

This guidebook describes generally benefits available to you under the various group plans. For detailed coverage information, exclusions and stipulations, please refer to the plan documents or contact your group

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insurance office or representative. All benefits under the group medical plan are provided pursuant to contracts between the County and various carriers. In the event of any inconsistencies between those contracts and this guidebook, or any omissions from this guidebook, the terms of contract shall prevail.

Plan documents and publications including detailed summary plan descriptions, benefits summaries, Summaries of Benefits and Coverage, New Health Insurance Marketplace Coverage Options and Your Health Coverage notice, forms, links to provider directories, compliance notices, and the Notice of Privacy Practices for Protected Health Information can be found online on the Group Insurance website at www.pbcgov.org/mybenefits or you can visit [MyBenefits](#) by selecting that option directly on the Palm Beach County intranet homepage.

In accordance with the provisions of the ADA, this information may be requested in an alternative format by contacting your group insurance office or representative.

Online Benefits Enrollment & Information System

Online enrollment is the required method for Board of County Commissioners and Palm Tran employees to enroll for group insurance benefits. Supervisor of Election employees will receive enrollment instructions from their group insurance office or representative. Online enrollment allows you to have access to your benefits information on demand and it significantly decreases the chance of errors that is more prevalent with paper form enrollment. It supports the Palm Beach County “Go Green” Initiative and allows us to improve the quality of our services and delivery of information. [MyBenefits](#) is the County's online benefits enrollment and information system. [MyBenefits](#) is fast, secure and conveniently available to you from any computer, anywhere, day or night! Use [MyBenefits](#), YOUR benefits information system for ease of mind and a better way to manage your insurance information!

Accessing and Using MyBenefits

Step 1: Simply enter the website address: www.pbcgov.org/mybenefits into your web browser or from work, Click on the link to **MyBenefits** from the County's intranet page, MyPBC



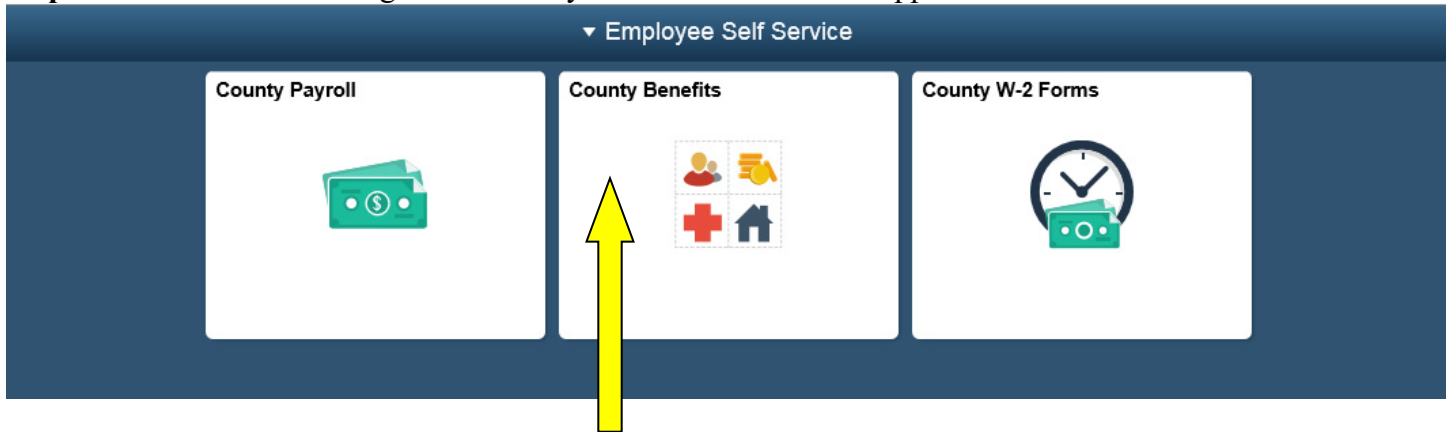
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Step 2: Enter your County issued User Name as the User ID (ALL CAPS) and Password (Case Sensitive) and click "Sign In":



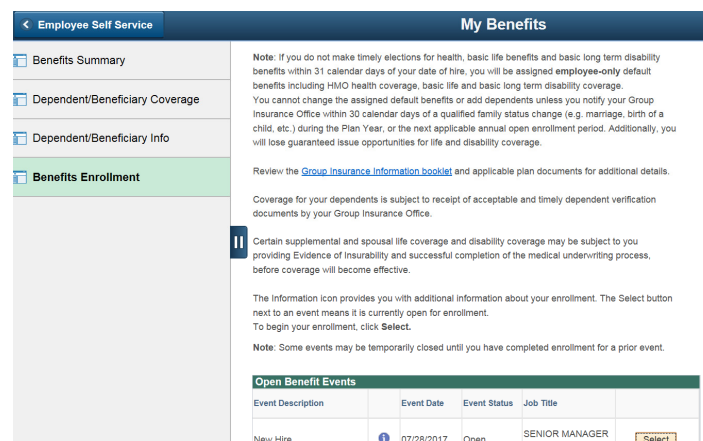
The image shows the Oracle PeopleSoft Sign In screen. At the top, the Oracle PeopleSoft logo is displayed. Below the logo, there are three input fields: "User ID", "Password", and "Select a Language" (with a dropdown menu showing "English"). A green "Sign In" button is located below the language dropdown. At the bottom, there is a link to "Enable Accessibility Mode".

Step 3: Use the links to navigate to “County Benefits” self service application:



Step 4: Use [MyBenefits](#) to review your group insurance information and dependent and beneficiary personal information. [MyBenefits](#) is available year-round for you to view your coverage, dependent information, update life insurance beneficiary information and print your detailed benefit confirmation statement. You can directly access plan documents, change forms, provider directories and other publications any time you need them.

Step 5: Benefits Enrollment - as a new hire and during the annual open enrollment period, you will be able to use [MyBenefits](#) to review benefit options and costs, and make elections and changes. Go to “Benefits Enrollment” and click the Select button next to the enrollment event to make or change your benefits choices within your enrollment period.



The image shows the "My Benefits" screen. On the left, there is a sidebar with navigation links: "Benefits Summary", "Dependent/Beneficiary Coverage", "Dependent/Beneficiary Info", and "Benefits Enrollment" (which is highlighted). The main content area is titled "My Benefits" and contains several sections of text and a table. A yellow arrow points to the "Select" button in the "Open Benefit Events" table.

Note: If you do not make timely elections for health, basic life benefits and basic long term disability benefits within 31 calendar days of your date of hire, you will be assigned **employee-only** default benefits including HMO health coverage, basic life and basic long term disability coverage. You cannot change the assigned default benefits or add dependents unless you notify your Group Insurance Office within 30 calendar days of a qualified family status change (e.g. marriage, birth of a child, etc.) during the Plan Year, or the next applicable annual open enrollment period. Additionally, you will lose guaranteed issue opportunities for life and disability coverage.

Review the [Group Insurance Information booklet](#) and applicable plan documents for additional details.

Coverage for your dependents is subject to receipt of acceptable and timely dependent verification documents by your Group Insurance Office.

II Certain supplemental and spousal life coverage and disability coverage may be subject to you providing Evidence of Insurability and successful completion of the medical underwriting process, before coverage will become effective.

The Information icon provides you with additional information about your enrollment. The Select button next to an event means it is currently open for enrollment. To begin your enrollment, click Select.

Note: Some events may be temporarily closed until you have completed enrollment for a prior event.

Open Benefit Events			
Event Description	Event Date	Event Status	Job Title
New Hire	07/28/2017	Open	SENIOR MANAGER OF RR

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Group Insurance Eligibility

All active full-time employees who are regularly scheduled to thirty (30) hours or more a week may qualify for coverage under the benefit plans described in this guide.

Further, non-full time (including seasonal and variable hour) employees are evaluated under the provisions of the Affordable Care Act (ACA). If it is determined at the conclusion of a measurement period that an employee in this category meets the definition of "full time" as defined by the ACA, future **medical** coverage will be offered to that employee. Employees in this category are subject to periodic evaluation of their hours worked to determine if the employee continues to meet the criteria of a full time employee and continues to be eligible for medical coverage, as outlined by the ACA.

Dependent Eligibility

You must be enrolled in benefits in order to enroll your eligible dependents. You may add your eligible dependents to the same Medical and/or Dental plans in which you enroll and in the group Life insurance plan. Eligible dependents are:

- Legal Spouse or Domestic Partner of the same or opposite sex who is not eligible for coverage as an employee. Note: A former spouse is NOT an eligible dependent and must be removed from an employee's coverage immediately following a divorce – even if a court order mandates that the employee has to continue to provide medical coverage for the former spouse.
IMPORTANT: You CANNOT be covered as a dependent on the medical, dental, or life insurance plans if you are eligible for coverage as an employee.
- Natural, adopted, step child, domestic partner child, foster child, child placed in your custody by a court order until the end of the month the child turns age 26 for medical or dental insurance and until the end of the calendar year in which the child reaches age 25 for life insurance coverage
- A child born to an insured Dependent child of yours until such child is 18 months old
- Qualified child from age 26 until the end of the calendar year in which the child reaches the age of 30 (provided child is unmarried and does not have a dependent of their own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of their own or entitled to benefits under title XVIII of the Social Security Act) may be covered for medical and dental plans. **IMPORTANT:** The rates for children in this category are illustrated in the "Over-aged Dependent Tier"; are paid entirely by the employee electing the coverage for each 26 - 30 year old dependent and are paid IN ADDITION to other selected tiers of coverage on a post-tax basis. Over-aged Dependents cannot participate in the life insurance plans
- Qualified child who is 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. The carrier will require supporting documents to approved coverage and periodically thereafter.

IMPORTANT: Your dependents who no longer meet the County's eligibility requirement can no longer remain under the group insurance plan, this includes a *former* spouse. Your group insurance office or representative will notify you 60 days before the coverage ends, due to age, and your dependent will be offered continuation coverage. If you experience a relevant qualifying event, it is your responsibility to notify your group insurance office or representative within 30 days of the event.

Employees May Not be Covered as Dependents

Individuals who are eligible for Group Insurance benefits as "employees" cannot be covered as a "dependent". This applies to the medical and dental plans; as well as spouse or domestic partner/dependent child life insurance. Individuals who are eligible for BCC group insurance benefits as an employee must elect coverage as an employee (instead of being covered as a dependent). Therefore, BCC benefits eligible dependents cannot be a dependent on any BCC plan.

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Proof of Eligibility

Proof of eligibility is required for all dependents added to the employee's coverage. Required documentation should be submitted to your group insurance office or representative upon hire, or when dependents are added during the plan year. Staff, at its discretion, may also require the documents referenced herein during the Open Enrollment period or any time during the plan year during random or formal file audits, or when circumstances arise that lead to a single file audit of an employee. It is hereby noted that when a third party is hired to conduct a dependent verification review, it may require additional information from what is noted herein.

If proof of eligibility is not provided with the plan enrollment, your Group Insurance office or representative will request it. Documentation must be received within 60 days of the request or the dependent may not be enrolled in, or remain in the plan(s). Such dependent would not be eligible for coverage until the next Open Enrollment period except in the case of a qualifying event.

If you are enrolling dependents, you must provide the required dependent verification documents by faxing them to BCC Group Insurance at 561-242-7184 or to Palm Tran at 561-841-4283; alternatively you can scan and email the information to BCCMyBenefits@pbcbgov.org. If all of the required dependent verification is not received, your dependent will not be enrolled in your coverage. Your next chance to enroll the dependent will be either within 31 days of a qualified family status change or during the next applicable annual Open Enrollment period, provided you are submitting the required dependent verification documents at that time.

IMPORTANT: Employees are cautioned to consider their covered dependents carefully to ensure dependents meet the criteria of a qualified dependent

- It is the employee's responsibility to ensure only qualified dependents are covered under his/her coverage and to timely remove ineligible dependents
- Dependent audits have been completed in the past and will be completed again in the future. Employees who are found to have non-qualified dependents covered are subject to disciplinary actions up to and including termination and repayments of any claims paid on behalf of the ineligible dependents. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison
- Employees must provide acceptable dependent verification documents for any dependents added during the benefits enrollment period
- Some of the individuals who are NOT eligible to be covered as a dependent under an employee's group insurance plan, are parents (even if claimed as a dependent on an employee's tax return), siblings, as well as a former spouse. Non-qualified dependents cannot be covered/remain covered under the employee's group insurance plans. This applies even if a court order mandates that an employee must continue to pay for or cover the former spouse. Court ordered coverage for a former spouse would have to be elected from a source, other than the Board's group insurance program.

Eligibility Documents

Refer to the following chart for required documentation:

Eligibility Categories	Required Documents
Spouse or Domestic Partner • Legal spouse	• Copy of page 1 of federal tax return of most current tax year as filed (personal and income information redacted) listing spouse • OR: Copy of marriage license/certificate; executed and recorded

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Domestic partner of the same or opposite sex	- Certificate or copy of executed, notarized and recorded Declaration of Domestic Partnership form (Ord. 2006-002) PLUS (Spouse OR Domestic Partner) Proof marriage/partnership is still current (recurring monthly or quarterly household bill or statement of account listing spouse's/partner's name at employee's address within the past 60 days)
Child up to end of the month the child turns age 26	
Biological child	Official birth certificate (hospital birth record not acceptable)
Adopted child	Official adoption documents
Foster child	Official documents, placing the child in employee's care
Child placed into custody by a court order	Court documented guardianship papers (Power of Attorney is not acceptable)
Step child	Executed, recorded marriage license/certificate of marriage to biological parent of child and birth certificate for child that names the employee's spouse as a parent
Child of Domestic Partner	- Birth verification as indicated above, depending on type of child (biological, adopted, foster child, or child placed into custody of Domestic Partner by a court order) plus executed, notarized and recorded Declaration of Domestic Partnership form (Ord. 2006-002) PLUS - Proof partnership is still current (recurring monthly or quarterly household bill or statement of account listing partner's name at employee's address within the past 60 days)
Child born to an insured dependent of the employee	Official birth certificate of child born to the employee's insured dependent
Child age 26 to 30	
Unmarried child age 26 up to until the end of the calendar year in which the child reaches the age of 30, provided child does not have a dependent of his/her own, is a Florida resident or a full-time or part-time student, and is not covered under a plan of his/her own or entitled to benefits under Title XVIII of the Social Security Act.	- Official birth certificate (hospital birth record not acceptable) - Copy of driver's license OR - State-issued ID showing s/he is a Florida resident OR - Copy of current school registration, confirming full-time or part-time student status
Disabled Child	
Qualified child who is 26 or more years old and primarily supported by the employee and incapable of self-sustaining employment by reason of mental or physical handicap	- Official birth certificate (hospital birth record not acceptable) - Official adoption documents - Official documents, placing the child in employee's care - Court documented guardianship papers (Power of Attorney is not acceptable)

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<i>Documentation required for other qualified events</i>	
Type of family status change	Documentation
Dissolution of Domestic Partnership	Executed, notarized and recorded Declaration of Termination of Domestic Partnership form (Ord. 2006-002)
Divorce (divorced spouses are not eligible for dependent coverage regardless of the court decree)	Final Divorce Decree
Death	Death certificate

Enrollment Opportunities

You have three opportunities to make benefit enrollment elections or changes, including but not limited to electing coverage, adding dependents, deleting dependents, changing coverage, or terminating coverage, etc.

- 1) **Newly Hired Employees:** As a new hire you must elect your benefits within 31 calendar days by accessing [MyBenefits](#) within 31 days of your date of hire and also provide the following documentation:
 - Dependent verification documentation as specified above
 - Proof of other health insurance if you decline/waive medical coverage and are eligible for the Opt-Out benefit
 - Completed Evidence of Insurability forms – if required – for group term life insurance

- 2) **After a Family Status Change or Life Event:** Employees or dependents that experience a Qualifying Event (QE) normally have 30 days from the date of the QE to make any changes to their benefits. QEs include family status changes such as marriage, divorce, beginning or ending of a domestic partnership, death of a spouse or dependent, birth or adoption/placement for adoption of a child, loss of other healthcare coverage or loss of dependent eligibility, change in spouse's/domestic partner's employment status, and initial entitlement to Medicare or Medicaid. If you experience a qualifying event, you must contact your respective group insurance office or representative to make appropriate changes to your coverage within 30 days of the date of the event.

Any change in your benefits must be consistent with the change in status. For example, if you get married, you may add your spouse to your medical coverage.

- 3) **During the annual Open Enrollment period** – Typically, Open Enrollment takes place each year beginning in the month of October. Employees are given the opportunity to review benefit plan options and make changes for the following plan year. All benefits chosen during Open Enrollment take effect on January 1st of the following year. The annual Open Enrollment period and information is widely communicated in advance.

You should consider your elections carefully as IRS regulations limit when you can add coverage or make changes during the year. Once enrolled you cannot change certain coverage elections outside the annual Open Enrollment period unless you have a qualifying event.

Employees who do not enroll within the appropriate enrollment period cannot enroll or make changes until the next applicable annual Open Enrollment period.

It is your responsibility to review enrollment information, which includes certain conditions and expectations. Failure to read, understand, participate in information sessions, and ask questions prior to enrollment deadlines will not constitute a valid reason for an exception. Failure to observe these important responsibilities could have serious consequences as well as causing you and/or your dependents to have no coverage for the plan year.

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Coverage Effective Date

New Employee: You are eligible for benefits on the first day of the month coinciding with or next following sixty (60) days of employment. For example, if your first day of work is May 15, your insurance coverage will be effective August 1. **Please note:** In accordance with the Affordable Care Act (ACA) a group health plan may not impose a waiting period in excess of 90 calendar days and the health plan complies with this requirement.

Transferred/promoted employee: A permanent employee who transfers from other than a full time employment to full time permanent category will be given the option to have coverage effective on the first day of the month immediately following his/her hire date with the Board of County Commissioners, Palm Tran or Supervisor of Elections; provided the employee has been continuously employed in that permanent other than full-time position for at least 60 consecutive calendar days. Further, an employee transferring from employment with a Palm Beach County Constitutional Officer or Palm Tran will be given the option to have coverage effective on the first day of the month immediately following his/her hire date with the Board of County Commissioners. Employees must be full time, scheduled to work 30 hours or more each week, to be eligible for coverage

Special enrollment due to QE: Your enrollment elections or changes made as a result of a qualifying event become effective on the 1st of the calendar month following your election. Exceptions may include birth of a child or death of dependent.

Annual open enrollment: Changes you make during Open Enrollment, or plans that you need to actively re-elect during open enrollment take effect on January 1st of the following year.

Premium Costs

The County shares the premium costs for medical and pays the entire premium cost for basic Term Life and basic Accidental Death and Dismemberment Insurance and for basic/core Long-term Disability for participants in the medical HMO or OAPIN plan. Employees pay a portion of the medical premiums and the full premium cost for dental insurance, additional life and AD&D insurance, spouse and AD&D insurance, and child life insurance, Short-term and voluntary/buy-up Long-term disability insurance. All premium rates are subject to change at the discretion of the Palm Beach County Board of County Commissioners.

Pre-Tax Benefit Plans

Pursuant to Section 125 of the Internal Revenue Code, all benefit plans other than the optional short and/or long term disability insurance plans are offered on a pre-tax basis for active employees whose premiums are paid through payroll deduction. Premium payments for medical, life insurance coverage up to \$50,000, flexible spending account contributions are deducted from the your gross income before taxes are applied; the amount paid for premiums is therefore tax-sheltered. By electing benefit plans on a pre-tax basis, the participant will pay less federal and Social Security taxes while receiving more take-home pay than an election of the same benefit plans with payment on a post-tax basis would yield.

Payroll Deductions

All insurance premiums costs, if any, are paid through payroll deductions. Premiums are deducted by a "pay-as-you-go" method. Premiums are deducted with the pay period that includes the coverage effective dates. Deductions are based on the payroll calendar and apply to the pay periods that contain the dates when coverage begins or ends.

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If you end coverage or resign, retire or terminate employment, coverage continues until the end of the month in which you are separating. Deductions will stop the first full pay period following the coverage end date for coverage termination and employment separation. Accordingly, deductions usually will be applied to any checks as long as the employee has coverage for all or some of the pay period for which the paycheck is processed.

Retroactive premium deductions or refunds may apply. It is your responsibility to review your deductions on each paycheck and notify your group insurance office or representative of any discrepancies IMMEDIATELY.

Domestic Partner Benefits

The Board of County Commissioners extends certain benefits to qualified Domestic Partners of employees. Domestic Partners and their eligible children may participate in the following group insurance benefits as a qualified dependent of the employee:

- Health
- Dental
- Long Term Disability (FAMILY SURVIVOR BENEFIT ONLY)
- Dependent Life Insurance
- Employee Assistance Program (EAP)
- Domestic Partner continuation of coverage (in lieu of COBRA)*

Domestic Partners and their eligible children will not be eligible to participate in the following benefits:

- COBRA
- Flexible Spending Account (Section 125 Plan)
- Any other Federal benefits covered by the legal definition of spouse or qualified beneficiary

Eligibility for Domestic Partner Benefits

You must provide your group insurance office with proof of Domestic Partnership for your Domestic Partner and/or domestic partner's dependent children to be eligible for benefits.

Premiums and Tax Implications for Domestic Partner Benefits

- The IRS allows employees to receive "tax free" insurance subsidies for themselves and their eligible dependents as defined under IRS guidelines
- Amounts attributable to coverage for a Domestic Partner and/or eligible dependents of a domestic partner; however, are excluded from this tax free subsidy
- Therefore, the value of the insurance subsidy which the employer funds for the coverage of a Domestic Partner and eligible dependents of a Domestic Partner will be considered "imputed income", and will be taxable to the employee
- This additional amount will be shown on your paycheck
- Further, employee contributions towards domestic partner coverage are processed on a post-tax basis
- A Domestic Partner's coverage under the Dental, LTD (family survivor benefit only) or Dependent Life will not be rated separately, because these benefits are voluntary and premiums are 100% employee paid. However, premiums paid for these benefits for Domestic Partner coverage will be applied after tax, as referenced above.
- There is no taxable cost to the employee for Domestic Partner participation in the Employee Assistance Program.

Domestic Partner Tax Equity Policy

Please review Domestic Partner Tax Equity Policy PPM# CW-P-082 which has the purpose of creating a compensation structure which will fund a tax equity policy for County employees with eligible domestic

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partners enrolled in the County's sponsored health insurance plans. PPMs are posted on the MyPBC Intranet under Publications > PPMs.

Domestic Partners and Medicare

- Domestic Partners may be subject to a Medicare Part B late enrollment penalty if they fail to enroll in Medicare Part B when first eligible
- Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age
- Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CIGNA is the Secondary Plan
- However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules, as applicable, will apply

Opt-Out Benefit

Employees may reject coverage for themselves and their dependents under the County's group medical plan if they are covered by another medical plan not funded by the Palm Beach County Board of County Commissioners. Employee who waive or "opt out" of the group medical plan receive a maximum \$1,000 annual benefit (paid at \$38.46 each pay period) provided they show evidence of other medical insurance coverage and actively waive medical coverage in MyBenefits.

Enrollment in this option does not affect your eligibility for dental, life, long term disability, short term disability or flexible benefits (FSAs)

- All Opt-Out participants (including new and current) must actively re-enroll each Plan Year.
- Retroactive funding/enrollment will not be processed if an employee did not timely enroll or re-enroll in this program for the new Plan Year.
- It is the employee's sole responsibility to review their paychecks and anticipated Opt-Out credit and notify their group insurance office of any errors or discrepancies regarding their Opt-Out credit IMMEDIATELY.
- The Opt-Out benefit is not provided to any employee who is enrolled in a plan to which the BCC contributes – including the health plan of the BCC, Palm Tran and Supervisor of Elections as well as any other entities that may join the BCC health plan in the future. Employees who are enrolled in the health plan of Palm Beach County Fire Rescue are also excluded from the Opt-Out benefit as long as BCC contributes towards the funding of the Fire Rescue health plan in accordance with the provisions of the Collective Bargaining Agreement.
- The Opt-Out credit is not provided to any employee whose spouse or other dependent is also covered by a health plan to which the Board of County Commissioners contributes.
- Employees and their dependents who opt out of the County's medical coverage cannot enroll or re-enroll in any of the medical plans sponsored by the County until the next Open Enrollment period or within 30 days from the date coverage ceases in the other group plan.

Medical Insurance

The County offers a Health Maintenance Organization (HMO), an Open Access Plus In Network (OAPIN), and a Point of Service plan (POS) through CIGNA.

Medical Insurance – CIGNA – The County shares the cost of the premium with employee

Plan	Level of coverage	Actual Cost	Monthly Employer Portion	Biweekly Employer Portion	Monthly Employee Portion	Biweekly Employee Portion
HMO	EE Only	\$794.28	\$763.28	\$381.64	\$31.00	\$15.50
	EE + 1	\$1,653.14	\$1,452.14	\$726.07	\$201.00	\$100.50
	EE+ 2 or more	\$2,268.30	\$1,928.30	\$964.15	\$340.00	\$170.00
	Overage Dep.*	\$476.56	\$0.00	\$0.00	\$476.56	\$238.28
OAPIN	EE Only	\$830.02	\$781.02	\$390.51	\$49.00	\$24.50
	EE + 1	\$1,727.54	\$1,452.54	\$726.27	\$275.00	\$137.50
	EE+ 2 or more	\$2,370.38	\$1,928.30	\$964.19	\$442.00	\$221.00
	Overage Dep.*	\$498.00	\$0.00	\$0.00	\$498.00	\$249.00
POS	EE Only	\$880.96	\$813.96	\$406.98	\$67.00	\$33.50
	EE + 1	\$1,808.38	\$1,480.38	\$740.19	\$328.00	\$164.00
	EE+ 2 or more	\$2,482.26	\$1,981.26	\$990.63	\$501.00	\$250.50
	Overage Dep.*	\$545.60	\$0.00	\$0.00	\$545.60	\$272.80
*Overage Dependent: Additional amounts for each dep. age 26– 30 will be added to rates for other levels of coverage and 100% employee paid on a post-tax basis						

CIGNA Network (HMO) medical plan highlights:

- In-network benefits only – if you use doctors or hospitals that are out-of-network, you will NOT be covered for services, except for emergency care
- Requires selection of a Primary Care Physician
- Primary care physician selected may be different for yourself and your dependents
- Requires referrals to receive in-network specialty care
- Prior authorization is required for certain services and benefits to be covered (e.g. inpatient hospital services, outpatient facility services, advanced radiological imaging such as MRIs)
- Direct access (no referral required) for OB/GYN services, chiropractor or podiatrist, mental health and substance abuse care and for a maximum of five (5) visits per contract year to dermatologist. Dermatology visits in addition to the five (5) mentioned before are subject to a referral from the primary care physician
- Guest privileges: If you or one of your dependents will be residing temporarily in another location where there is a CIGNA HMO Network, you may be eligible for Managed Health Care Benefits at that location. Contact CIGNA customer service or the on-site CIGNA representative for more information

Cigna Open Access Plus In Network (OAPIN) medical plan highlights:

- In-network benefits only – if you use doctors or hospitals that are out-of-network, you will NOT be covered for services, except for emergency care
- OAPIN provider network is a ***national*** network with providers in all 50 states
- Designation of a Primary Care Physician is encouraged, but not required
- Does not require referrals for specialty care (has to be in-network)

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- Prior authorization is required for certain services and benefits to be covered (e.g. inpatient hospital services, outpatient facility services, advanced radiological imaging such as MRIs)

CIGNA Network (POS) medical plan highlights:

- Operates exactly like Network HMO Plan when receiving in-network benefits
- Therefore, for in-network benefits primary care physician selection is required as well as referrals; direct access is available as explained under HMO plan
- However, this plan offers out-of-network benefits, subject to deductibles and co-insurance (percentage cost share). Out of network services are subject to a maximum reimbursable charge and members may be balance billed for the difference
- Prior authorization is required for certain services and benefits to be covered (e.g. inpatient hospital services, outpatient facility services, advanced radiological imaging such as MRIs)
- Guest privileges: If you or one of your dependents will be residing temporarily in another location where there is a CIGNA HMO Network, you may be eligible for Managed Health Care Benefits at that location. Contact CIGNA customer service or the on-site CIGNA representative for more information

Medical Plan Highlights (limited)

<i>Medical Plan Highlights</i>	Network (HMO)	OAPIN	Network POS	
Annual deductibles and maximums	In-network Only	In-network Only	In-network	Out-of-network
Plan year deductible After each family member meets his or her individual deductible, the plan will pay his or her claims, less any coinsurance amount. After the family deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount.	Employee \$0 Employee and family \$0	Employee \$0 Employee and family \$0	Employee \$0 Employee and family \$0	Per Individual \$500
Pre-existing Condition Limitation	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Plan year out-of-pocket maximum The amount you pay for any services counts towards both your in-network and out-of-network out-of-pocket maximums.	Employee \$2,500 Employee and family \$5,000	Employee \$2,500 Employee and family \$5,000 Employee \$3,850 Employee and family \$7,700	Employee \$2,500 Employee and family \$5,000	Employee \$3,000 Employee and family \$6,000
Pharmacy out-of-pocket maximum Retail and Home Delivery copays apply to the Pharmacy out-of-pocket maximum	Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700	

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<i>Medical Plan Highlights</i>	Network (HMO)	OAPIN	Network POS	
Benefits	In-network Only	In-network Only	In-network	Out-of-network
	Physician services			
Office visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	You pay 30% Plan pays 70% after the deductible is met
	Preventive care			
Routine preventive care Includes well-baby, well-child, well-woman and adult preventive care Immunizations are covered at no charge.	No charge	No charge	No charge	Out-of-network preventive care including immunizations for children through age 16 are covered at plan coinsurance with no deductibles.
Preventive Mammogram, PSA, Pap Smear Includes charges for the procedure itself and the professional reading charge.	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met

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<i>Medical Plan Highlights</i>	Network (HMO)	OAPIN	Network POS	
Benefits	In-network Only	In-network Only	In-network	Out-of-network
	Lab and X-ray			
Lab and X-ray Physician's office Independent lab facility Outpatient hospital facility	No charge	Physician's Office – Primary Care Physician, you pay \$20 per visit Specialist, you pay \$40 per visit Independent Lab, Outpatient Facility – No charge *Radiology not applicable at Independent Lab	No charge	You pay 30% Plan pays 70% after the deductible is met
Advanced radiological imaging MRI, MRA, CT Scan, PET Scan, etc. Inpatient facility	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Advanced radiological imaging MRI, MRA, CT Scan, Pet Scan, etc. Emergency Room/Urgent Care Facility	No charge	No charge	No charge	No charge
Advanced radiological imaging MRI, MRA, CT Scan, PET Scan, etc. Outpatient facility Physician's office	You pay a per scan copay of \$150, then no charge	You pay a per scan copay of \$150, then no charge	You pay a per scan copay of \$150, then no charge	You pay 30% Plan pays 70% after the deductible is met

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<i>Medical Plan Highlights</i>	Network (HMO)	OAPIN	Network POS	
Benefits	In-network Only	In-network Only	In-network	Out-of-network
Emergency and urgent care services				
Hospital emergency room Including radiology, pathology and physician charges ER Copay waived if admitted Inpatient copays applies	No charge after \$200 per visit copay	No charge after \$200 per visit copay	No charge after \$200 per visit copay	
Inpatient Professional Services For services performed by surgeons, radiologists, pathologists and anesthesiologists	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Urgent care services <i>Please note urgent care CANNOT give a referral for an MRI, for advanced radiology imaging services or for specialists</i>	No charge after \$25 per visit copay	No charge after \$25 per visit copay	No charge after \$25 per visit copay	
Convenience Care Centers	You pay \$20 per visit	You pay \$20 per visit	You pay \$20 per visit	You pay 30% Plan pays 70% after the deductible is met

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<i>Medical Plan Highlights</i>	Network (HMO)	OAPIN	Network POS	
Benefits	In-network Only	In-network Only	In-network	Out-of-network
	Inpatient hospital facility services			
Semi-private room and board and other non-physician services Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. Private room stays may result in extra charges for the patient.	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
Inpatient Professional Services For services performed by surgeons, radiologists, pathologists and anesthesiologists	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
	Outpatient services			
Outpatient surgery (facility charges) Non-surgical treatment procedures are not subject to the facility copay	\$150 copay per visit, then Plan pays 100%	\$150 copay per visit, then Plan pays 100%	\$150 copay per visit, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met

<i>Medical Plan Highlights</i>	Network (HMO)	OAPIN	Network POS	
Benefits	In-network Only	In-network Only	In-network	Out-of-network
Physical, occupational, cognitive and speech therapy Unlimited days for all therapies combined per plan year • Includes cardiac rehabilitation, physical therapy, speech therapy, occupational therapy, spinal manipulation services (includes chiropractors), pulmonary rehabilitation and cognitive therapy	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
Maternity Care Services				
Physician's office – Initial Visit to confirm pregnancy	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	You pay 30% Plan pays 70% after the deductible is met
Physician's office – Subsequent prenatal visits, postnatal visits, and physician's delivery charges (i.e. global maternity fee)	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met

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Medical Plan Highlights	Network (HMO)	OAPIN	Network POS	
Benefits	In-network Only	In-network Only	In-network	Out-of-network
Delivery – Facility (inpatient Hospital, Birthing Center)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
	Special Services			
Skilled nursing facility, rehabilitation hospital and other facilities 90 days per plan year	No charge	No charge	No charge	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
Home health care Network (HMO) and OAPIN - Unlimited days per plan year Network POS – unlimited days per plan year In-Network and limited to 100 days maximum per plan year Out-of-Network Includes private duty nursing when approved as medically necessary.	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Hospice Inpatient services Outpatient services	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met

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<i>Medical Plan Highlights</i>	Network (HMO)	OAPIN	Network POS	
Benefits	In-network Only	In-network Only	In-network	Out-of-network
Durable medical equipment Unlimited plan year maximum	No charge	No charge	No charge	\$200 Deductible then No charge
External prosthetic appliances (EPA) Unlimited plan year maximum	No charge	No charge	No charge	You pay 30% Plan pays 70%
Mental health and substance abuse services				
Inpatient physician's office services Unlimited days per plan year	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, Then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then you pay 30% Plan pays 70% after the deductible is met
Outpatient physician's office services Unlimited visits per plan year This includes group therapy mental health and intensive outpatient mental health	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met

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Prescription Plan Highlights

Prescription Plan Highlights		Network (HMO)	OAPIN	Network POS	
Benefits		In-network	In-network	In-network	Out-of-network
	Special Services				
CIGNA Pharmacy three-tier copay plan Self administered Injectable and optional Injectable drugs – excludes infertility drugs Note: Effective 01/01/13, as a result of health care reform certain categories of drugs and other products have been included in the preventive care services coverage. The coverage emphasizes the prevention of disease and meeting the unique health care needs of women. For a list of specific products and prescriptions medications (as well as specific over-the-counter medications) which will be available at no cost please review the information please contact Cigna for more information.		Retail (30 day supply) <u>You pay:</u> Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70	Retail (30 day supply) <u>You pay:</u> Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70	Retail (30 day supply) <u>You pay:</u> Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70	Retail (30 day supply) You pay 30% Plan pays 70%
		Home Delivery (90 day supply) <u>You pay:</u> Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140	Home Delivery (90 day supply) <u>You pay:</u> Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140	Home Delivery (90 day supply) <u>You pay:</u> Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140	Home Delivery Not covered
Pharmacy out-of-pocket maximum Retail and Home Delivery copays apply to the Pharmacy out-of-pocket maximum		Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700

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Prescription Plan Highlights		Network (HMO)	OAPIN	Network POS	
Benefits		In-network	In-network	In-network	Out-of-network
Prescription smoking cessation drugs & OTC with a prescription		Covered - no copay applied	Covered - no copay applied	Covered - no copay applied	Not covered
	Note: The CIGNA Prescription Drug List is available on www.myCIGNA.com to help you determine the cost of your prescribed medication.				

90-DAY PRESCRIPTION FILLS

Filling your maintenance medications just got easier with Cigna 90 NowSM

You have a lot going on. Taking your medication every day and remembering to pick up your refill every month isn't always easy. We have a program that can help – it's called Cigna 90 Now.

More choice

Your plan includes a new maintenance medication program called Cigna 90 Now. Maintenance medications are taken regularly, over time, to treat an ongoing health condition. **Cigna 90 Now offers you more choice in how, and where, you can fill your prescription.**

Choose what works best for you

- › If you choose to fill your prescription in a 90-day supply, you have to use a 90-day retail pharmacy in your plan's new network, or Cigna Home Delivery PharmacySM.*
- › If you choose to fill your prescription in a 30-day supply, you can use any retail pharmacy in your plan's new network.



You choose! 90-day or 30-day supply.

Where you can fill a 90-day prescription

With Cigna 90 Now, your plan offers a new retail pharmacy network that gives you more choice in where you can fill your 90-day prescriptions.

There are thousands of retail pharmacies in your new network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop! If you prefer the convenience of having your medications delivered to your home, you can also use Cigna Home Delivery Pharmacy to fill your prescriptions.*

For more information about your new pharmacy network, you can go to **Cigna.com/Rx90network**.



Why fill a 90-day supply?

Filling your prescriptions in a 90-day supply may help you stay healthy because having a 90-day supply of your medication on-hand typically means you're less likely to miss a dose.** It also means you can make fewer visits to the pharmacy to refill your medication, and depending on your plan, you may be able to save money by filling your prescriptions 90-days at a time.

Here are some of the 90-day retail pharmacies in your network:***

- › **CVS** (including Target and Navarro)
- › **Walmart**
- › **Kroger** (including Harris Teeter Pharmacy, Pick N Save Pharmacy, Fred Meyer Pharmacy, Fry's Food and Drug)
- › **Access Health** (including Benzer Pharmacy, Marcs, Big Y Pharmacy, Marsh Drugs, LLC, Snyder Drug Emporium)
- › **Good Neighbor Pharmacies** (including Big Y Pharmacy, Super RX Pharmacy, Medical Center Pharmacy, Family Pharmacy, King Kullen Pharmacy)
- › **Cardinal Health** (including Freds Pharmacy, Medicine Shoppe Pharmacy, Harris Teeter Pharmacy, Medicap Pharmacy)

Together, all the way.®



Prefer to have your medications delivered to your door?

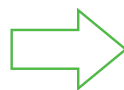
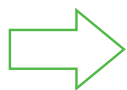
Then Cigna Home Delivery Pharmacy may be right for you! We'll deliver your maintenance medication to you at the location of your choice. And standard shipping is always free. No more waiting in line at the pharmacy! For more information, please call Customer Service at **800.285.4812**, or visit **Cigna.com/home-delivery-pharmacy**.



Questions?

Please call Customer Service using the number on the back of your Cigna ID card. We're here to help.

90-Day Fills



Get a 90-day prescription for your medication

Take your prescription to a 90-day retail pharmacy in your network, or mail to Cigna Home Delivery Pharmacy

Receive your medication in a 90-day supply for convenience

30-Day Fills



Get a 30-day prescription for your maintenance medication

Take your prescription to any retail pharmacy in your network

Receive your medication

* Plans vary, so some plans may not include Cigna Home Delivery Pharmacy. Please check your plan materials for more information on what pharmacies are covered under your plan.

** Internal Cigna analysis performed March 2016, utilizing 2015 Cigna national book of business average medication adherence (customer adherent > 80% PDC), 90-day supply vs. those who received a 30-day supply taking antidiabetics, RAS antagonist and statins.

*** Participating 90-day network pharmacies as of April 2016. Subject to change.

Para obtener ayuda en español llame al número en su tarjeta de Cigna.

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.

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Medical Benefit Exclusions

EXCLUSIONS

Medical Benefit Exclusions (*by way of example but not limited to*):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies;" or the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies."
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Rhinoplasty; Blepharoplasty; Orthognathic surgeries, except when Medically Necessary; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
- Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male and female voluntary sterilization procedures.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or

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EXCLUSIONS

maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Section IV. Covered Services and Supplies".
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
- Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations and telemedicine.
- Massage Therapy

These are only the highlights

The summary above outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see the insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

CIGNA'S 24-hour Health Information Service

- 24/7 online and phone assistance to find doctors, specialists, hospitals, labs and pharmacies close to home or when you are traveling at www.mycigna.com or customer service at 1.800.CIGNA24 (1.800.244.6224)
- Talk to a trained nurse for information, when you can't reach your doctor – day or night
- Self-service through myCIGNA.com lets you:
 - Print forms or print/order ID cards
 - Check your coverage
 - Track claims, payments and deductibles
 - View, print and download your Explanation of Benefits
 - Access articles and health education resources, and sign up for online coaching programs
 - Keep track of your health history and records with a secure online database
 - Award-winning decision support tools
 - Learn about common health problems and options for treatment
 - Find doctors, hospitals, specialists and labs
 - Compare treatment and procedure costs
 - Switch a prescription to CIGNA Home Delivery Pharmacy with one easy phone call and have your medications delivered to your door
- Emergency & Urgent Care
 - Emergency care is covered 24 hours a day, in or out of the network
 - Avoid the emergency room for minor injuries – visits to urgent care and convenience care clinics are covered. Examples:
 - \$200 emergency room copay per visit
 - \$25 urgent care copay per visit
 - \$20 convenience care clinic copay per visit (in-network only)
- Find updated participating urgent care and convenience care provider information by contacting CIGNA at 1.800.CIGNA24 or 1.800.244.6224 or visit www.myCIGNA.com.

HEALTHY CHOICES DESERVE HEALTHY DISCOUNTS

Start saving today with Cigna Healthy Rewards®*

Just use your ID card when you pay and let the savings begin.

Get discounts on the health products and programs you use every day for:

- Weight management and nutrition
- Fitness
- Mind/body
- Vision and hearing care
- Alternative medicine
- Healthy lifestyle

Real brands. Real discounts. Real awesomeness.

* Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your health plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your plan benefits. **A discount program is NOT insurance, and you must pay the entire discounted charge.** All goods, services and discounts offered through Healthy Rewards are provided by third parties who are solely responsible for their products, services and discounts.



To start saving today,
visit [cigna.com/healthyrewards](#) or
call 1-800-453-2222

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Dental Insurance

The County offers three dental plans through Solstice Benefits, Inc. Employees can choose from a DHMO and two PPO plans:

Dental Insurance – Solstice Benefits, Inc. – Premiums are 100% employee paid

Plans	Solstice DHMO		Solstice Low PPO		Solstice High PPO	
Level of Coverage	Actual Monthly Cost	Biweekly Deduction	Actual Monthly Cost	Biweekly Deduction	Actual Monthly Cost	Biweekly Deduction
EE Only	\$11.16	\$5.58	\$17.21	\$8.61	\$32.33	\$16.17
EE + 1	\$19.09	\$9.55	\$32.67	\$16.34	\$61.95	\$30.98
EE+ 2	\$25.87	\$12.94	\$39.96	\$19.98	\$71.57	\$35.79
EE+ 3 or more	\$34.13	\$17.07	\$55.49	\$27.75	\$101.22	\$50.61

DHMO Plan

Solstice S700A-PBC, the DHMO Dental Plan is a pre-paid plan. It is an open-access plan, so you do not have to select a primary care dentist. However, all services must be obtained from a participating network dentist or specialist. This plan offers a guaranteed savings of 25% to 50% on basic and major dental services. What you will pay the dentist on your visit is listed in your Schedule of Benefits. With this plan there are no hidden charges. Additionally, you will receive the following features:

- No deductibles
- No waiting periods
- No claim forms to submit
- No annual benefit dollar maximums
- Coverage for pre-existing conditions
- No primary dentist selection required as this plan has open access provider network
- Ability to change dentist at any time
- Specialist coverage at same general dentist copay level with Solstice authorization, or self-referral for a 25% discount
- Defined copayment on over **400** procedures codes
- Two (2) free routine cleanings a year (one every six months)
- Two (2) free evaluations a year (one every six months)
- Implant coverage at copayment level through the Solstice network of implant specialists
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included
- 25% discount on all procedure codes that are not listed on the Schedule of Benefits
- Orthodontic treatment is covered for both children and adults
- **Note:** The DHMO is available in Florida, Georgia, New York, New Jersey and Connecticut. Within Florida, the plan has networks in 48 of Florida's 67 counties, including Palm Beach, Broward, Hendry, Martin, Miami Dade, St. Lucie counties.
- Search for providers on www.solsticebenefits.com (Select: Product: Dental - Select a plan: **S700, S700A, S700AP & S700B-SHP**) or contact **855-494-0098**

Services for DHMO Plan

- Fees within the Schedule of Benefits apply when such services are performed by a participating Solstice in-network general dentist, or self-referral for a 25% discount

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- If services are not listed within the Schedule of Benefits and are performed by a participating Solstice in-network general dentist, the member will be charged at the dentist's usual and customary fee less 25%.
- The participating Solstice in-network general dentist you select may not perform all outlined procedures. The co-payment shown applies to general dentists who perform these procedures.
- Should the services of a specialist (Oral Surgeon, Endodontist, Periodontist or Prosthodontist) be necessary, you may receive this care in one of two ways: (1) You may go directly to a participating in-network specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating Solstice in-network specialist at the listed co-payment.
- Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member co-pay.
- Members do not require a pre-authorization on the DHMO to access the Orthodontist or Pediatric dentist. Members may find a Solstice participating in-network Orthodontist or Pedodontist and schedule an appointment

Please review the detailed Schedule of Benefits and Implant Service Member Fee Schedule for more information. Always refer to your Schedule of Benefits or call Solstice to ensure that you receive the maximum benefit from your dental plan.

Using a Pedodontist

A Pedodontist, or Pediatric Dentist, is a dental specialist who only treats children. Their offices are set up with smaller dental chairs and many have games for the children to play in the waiting area. This warmer, more "fun" office environment helps to eliminate the child's fear of going to the dentist.

With the DHMO plan you have the choice to select the participating dentist that best satisfies the needs of each individual. Children are covered at the Pediatric Dentist up to age 16 and do not require a referral from a General Dentist. Visits to the participating Pediatric Dentist for covered routine preventive and diagnostic dental work (exams, X-rays, cleanings, fluoride, sealants, and space maintainers) are allowed without a pre-authorization. However, if additional treatment is needed, you may need pre-authorization. For additional treatment, you may receive this care in either of two ways: 1) You may go directly to a participating Pediatric Dentist and receive a 25% reduction off the provider's Usual and Customary fee; or 2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating specialist at the listed co-payments. With the open access provider network, you have the option to select a Pedodontist for your child without a pre-authorization or you may choose to have your child see a General Dentist. The choice is yours, and Solstice allows you to make the best choice for you and your family.



S700A-PBG

Dental Plan Schedule of Benefits

Solstice
PO Box 19199
Plantation, FL 33318
Telephone; 1.877.760.2247
Fax: 954-370-1701
www.mysolstice.net

Members of the S700A - PBG Dental Plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No waiting Periods
- No Deductibles or Maximums
- No claim forms to submit

The Member co-payments listed are offered by a participating in-network provider. The member receives:

- Most diagnostic & preventive care at No Charge
- Cosmetic & Orthodontia treatment covered

Members can choose a participating provider at
www.SolsticeBenefits.com
Member Services Department: 1.877.760.2247

The patient/member is ultimately responsible for verifications to the accuracy and appropriateness of all fees applicable to any dental benefit provided by a network provider. We urge all of our members to verify all fees for proposed treatment via the "Schedule of Benefits" and/or with our Member Services Department prior to treatment.

The following Member co-payments apply when a participating General Dentist performs services. An "***" denotes limitations on certain benefits (see "Exclusions/Limitations").

CODE	DESCRIPTION	MEMBER COPAY	CODE	DESCRIPTION	MEMBER COPAY
CLINICAL ORAL EVALUATIONS			D0274	*Bitewings - four radiographic images	No Charge
D0120	*Periodic oral evaluation - established patient	No Charge	D0277	*Vertical bitewings - 7 to 8 radiographic images	No Charge
D0140	Limited oral evaluation - problem focused	20.00	D0310	Sialography	150.00
D0145	*Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge	D0320	"Temporomandibular joint arthrogram, including injection"	250.00
D0150	*Comprehensive oral evaluation - new or established patient	No Charge	D0321	Other temporomandibular joint radiographic images, by report	150.00
D0160	*Detailed and extensive oral evaluation - problem focused, by report	10.00	D0322	Tomographic survey	150.00
D0170	"Re-evaluation - limited, problem focused (established patient; not post-operative visit)"	10.00	D0330	*Panoramic radiographic images	No Charge
D0171	Re-evaluation - post-operative office visit	No Charge	D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	125.00
D0180	***Comprehensive periodontal evaluation - new or established patient"	10.00	D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	20.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	60.00	D0364	***Cone beam CT capture and interpretation with limited field of view - less than one whole jaw"	149.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Charge	D0365	*Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	139.00
D9440	Office visit - after regularly scheduled hours	35.00	D0366	*Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	139.00
D9450	Case presentation, detailed and extensive treatment planning	No Charge	D0367	*Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	184.00
D9986	Missed appointment	25.00	D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	139.00
DIAGNOSTIC IMAGING			D0369	*Maxillofacial MRI capture and interpretation	189.00
D0210	*Intraoral - complete series (including bitewings)	No Charge	D0370	*Maxillofacial ultrasound capture and interpretation	169.00
D0220	Intraoral - periapical first radiographic images	No Charge	D0371	*Sialoendoscopy capture and interpretation	169.00
D0230	Intraoral - periapical each additional radiographic images	No Charge	D0380	***Cone beam CT image capture with limited field of view - less than one whole jaw"	149.00
D0240	Intraoral - occlusal radiographic images	No Charge	D0381	***Cone beam CT image capture with field of view of one full dental arch - mandible"	139.00
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No Charge	D0382	***Cone Beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium"	139.00
D0251	*Extra-oral posterior dental radiographic image	No Charge	D0383	***Cone beam CT image capture with field of view of both jaws, with or without cranium"	184.00
D0270	*Bitewing - single radiographic images	No Charge	D0384	***Cone beam CT image capture for TMJ series including two or more exposures"	139.00
D0272	*Bitewings - two radiographic images	No Charge			
D0273	*Bitewings - three radiographic images	No Charge			

"Administered and Underwritten by Solstice Benefits, Inc. a Life and Health Insurer under the Florida Insurance Code
authorized to write Prepaid Limited Health Service Organization Business"

CODE	DESCRIPTION	MEMBER COPAY	CODE	DESCRIPTION	MEMBER COPAY
D0385	*Maxillofacial MRI image capture	169.00			
D0386	*Maxillofacial ultrasound image capture	169.00			
D0393	*Treatment simulation using 3d image volume	9.00			
D0394	***Digital subtraction of two or more images or image volumes of the same modality"	9.00	D2140	AMALGAMS RESTORATIONS (INCLUDING POLISHING) Amalgam - one surface, primary or permanent	5.00
D0395	***Fusion of two or more 3D image volumes of one or more modalities"	9.00	D2150	Amalgam - two surfaces, primary or permanent	10.00
			D2160	Amalgam - three surfaces, primary or permanent	25.00
			D2161	"Amalgam - four or more surfaces, primary or permanent"	40.00
	TESTS AND EXAMINATIONS			RESIN BASED COMPOSITE RESTORATIONS - DIRECT	
D0415	"Collection of microorganisms for culture and sensitivity"	No Charge	D2330	Resin-based composite - one surface, anterior	30.00
D0425	Caries susceptibility tests	No Charge	D2331	Resin-based composite - two surfaces, anterior	37.00
D0431	"Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures"	65.00	D2332	Resin-based composite - three surfaces, anterior	50.00
D0460	Pulp vitality tests	No Charge	D2335	"Resin-based composite - four or more surfaces or involving incisal angle (anterior)"	65.00
D0470	Diagnostic casts	No Charge	D2390	Resin-based composite crown, anterior	115.00
	ORAL PATHOLOGY LABORATORY		D2391	Resin-based composite - one surface, posterior	60.00
D0472	"Accession of tissue, gross examination, preparation and transmission of written report"	No Charge	D2392	Resin-based composite - two surfaces, posterior	70.00
D0473	"Accession of tissue, gross and microscopic examination, preparation and transmission of written report"	No Charge	D2393	Resin-based composite - three surfaces, posterior	80.00
D0474	"Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report"	No Charge	D2394	Resin-based composite - four or more surfaces, posterior	110.00
D0480	"Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report"	No Charge		GOLD FOIL RESTORATIONS	
D0486	"Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report"	No Charge	D2410	Gold foil - one surface	75.00
D0502	Other oral pathology procedures, by report	No Charge	D2420	Gold foil - two surfaces	95.00
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	No Charge	D2430	Gold foil - three surfaces	125.00
D0601	"Caries risk assessment and documentation, with a finding of low risk"	No Charge		INLAY/ONLAY RESTORATIONS	
D0602	"Caries risk assessment and documentation, with a finding of moderate risk"	No Charge	D2510	Inlay - metallic - one surface	100.00
D0603	"Caries risk assessment and documentation, with a finding of high risk"	No Charge	D2520	Inlay - metallic - two surfaces	120.00
	DENTAL PROPHYLAXIS		D2530	Inlay - metallic - three or more surfaces	150.00
D1110	*Prophylaxis - adult	No Charge	D2542	Onlay - metallic-two surfaces	210.00
D1110	Additional prophylaxis - adult	20.00	D2543	Onlay - metallic-three surfaces	220.00
D1120	*Prophylaxis - child	No Charge	D2544	Onlay - metallic-four or more surfaces	220.00
D1120	Additional prophylaxis - child	20.00	D2610	Inlay - porcelain/ceramic - one surface	200.00*
	TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		D2620	Inlay - porcelain/ceramic - two surfaces	210.00*
D1206	*Topical fluoride varnish	15.00	D2630	Inlay - porcelain/ceramic - three or more surfaces	220.00*
D1208	*Topical application of fluoride - excluding varnish	No Charge	D2642	Onlay - porcelain/ceramic - two surfaces	360.00*
D9910	*Application of desensitizing medicament	20.00	D2643	Onlay - porcelain/ceramic - three surfaces	390.00*
	OTHER PREVENTIVE SERVICES		D2644	Onlay - porcelain/ceramic - four or more surfaces	400.00*
D1310	Nutritional counseling for control of dental disease	No Charge	D2650	Inlay - resin-based composite - one surface	255.00
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge	D2651	Inlay - resin-based composite - two surfaces	240.00
D1330	Oral hygiene instructions	No Charge	D2652	Inlay - resin-based composite - three or more surfaces	270.00
D1351	*Sealant - per tooth	10.00	D2662	Onlay - resin-based composite - two surfaces	245.00
D1352	***Preventive resin restoration in a moderate to high caries risk patient - permanent tooth"	No Charge	D2663	Onlay - resin-based composite - three surfaces	265.00
D1353	Sealant repair - per tooth	No Charge	D2664	Onlay - resin-based composite - four or more surfaces	285.00
D1354	*Interim caries arresting medicament application - per tooth	20.00		CROWNS - SINGLE RESTORATIONS ONLY	
	SPACE MAINTAINERS (PASSIVE APPLIANCES)		D2710	*Crown - resin-based composite (indirect)	195.00
D1510	*Space maintainer - fixed - unilateral	No Charge	D2712	*Crown - ¾ resin-based composite (indirect)	195.00
D1516	*Space maintainer - fixed - bilateral, maxillary	No Charge	D2720	*Crown - resin with high noble metal	255.00*
D1517	*Space maintainer - fixed - bilateral, mandibular	No Charge	D2721	*Crown - resin with predominantly base metal	255.00*
D1520	*Space maintainer - removable - unilateral	No Charge	D2722	*Crown - resin with noble metal	255.00*
D1526	*Space maintainer - removable - bilateral, maxillary	No Charge	D2740	*Crown - porcelain/ceramic	255.00*
D1527	*Space maintainer - removable - bilateral, mandibular	No Charge	D2750	*Crown - porcelain fused to high noble metal	255.00*
D1550	Re-cementation or re-bond space maintainer	15.00	D2751	*Crown - porcelain fused to predominantly base metal	255.00*
D1555	Removal of fixed space maintainer	15.00	D2752	*Crown - porcelain fused to noble metal	255.00*
D1575	Distal shoe space maintainer - fixed - unilateral	No Charge	D2780	*Crown - 3/4 cast high noble metal	255.00*
			D2781	*Crown - 3/4 cast predominantly base metal	255.00*
			D2782	*Crown - 3/4 cast noble metal	255.00*
			D2783	*Crown - 3/4 porcelain/ceramic	255.00*
			D2790	*Crown - full cast high noble metal	255.00*
			D2791	*Crown - full cast predominantly base metal	255.00*
			D2792	*Crown - full cast noble metal	255.00*
			D2794	*Crown - titanium	255.00*
			D2799	***Provisional crown - further treatment or completion of diagnosis necessary prior to final impression"	125.00
				OTHER RESTORATIVE SERVICES	
			D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	15.00
			D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	20.00
			D2920	Re-cement or re-bond crown	15.00
			D2921	Reattachment of tooth fragment, incisal edge or cusp	15.00
			D2929	*Prefabricated porcelain/ceramic crown - primary tooth	49.00*

CODE	DESCRIPTION	MEMBER COPAY	CODE	DESCRIPTION	MEMBER COPAY
D2930	Prefabricated stainless steel crown - primary tooth	60.00	D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	90.00
D2931	Prefabricated stainless steel crown - permanent tooth	60.00			
D2932	Prefabricated resin crown	95.00		APICOECTOMY/PERIRADICULAR SERVICES	
D2933	Prefabricated stainless steel crown with resin window	145.00	D3410	Apicoectomy - anterior	100.00
D2940	Protective restoration	15.00	D3421	Apicoectomy - premolar (first root)	155.00
D2941	Interim therapeutic restoration - primary dentition	15.00	D3425	Apicoectomy - molar (first root)	205.00
D2949	Restorative foundation for an indirect restoration	20.00	D3426	Apicoectomy (each additional root)	95.00
D2950	Core buildup, including any pins when required	70.00	D3427	Periradicular surgery without apicoectomy	100.00
D2951	Pin retention - per tooth, in addition to restoration	15.00	D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	47.00
D2952	Post and core in addition to crown, indirectly fabricated	88.00	D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	42.00
D2953	Each additional indirectly fabricated post - same tooth	95.00	D3430	Retrograde filling - per root	35.00
D2954	Prefabricated post and core in addition to crown	75.00	D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	150.00
D2955	Post removal	30.00	D3432	Guided tissue regeneration in conjunction with per site, in conjunction with periradicular surgery	150.00
D2957	Each additional prefabricated post - same tooth	30.00	D3450	Root amputation - per root	70.00
D2960	Labial veneer (resin laminate) - chairside	200.00	D3460	Endodontic endosseous implant	545.00
D2961	Labial veneer (resin laminate) - laboratory	255.00*	D3470	Intentional reimplantation (including necessary splinting)	175.00
D2962	Labial veneer (porcelain laminate) - laboratory	315.00*			
D2971	Additional procedures to construct new crown under existing partial denture framework	45.00		OTHER ENDODONTIC PROCEDURES	
D2975	Coping	95.00	D3910	Surgical procedure for isolation of tooth with rubber dam	95.00
D2980	Crown repair necessitated by restorative material failure	25.00	D3920	Hemisection (including any root removal), not including root canal therapy	80.00
D2981	Inlay repair necessitated by restorative material failure	95.00	D3950	Canal preparation and fitting of preformed dowel or post	75.00
D2982	Onlay repair necessitated by restorative material failure	95.00		SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)	
D2983	Veneer repair necessitated by restorative material failure	95.00	D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	120.00
D2990	Resin infiltration of incipient smooth surface lesions	29.00	D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	65.00
	PULP CAPPING		D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	49.00
D3110	Pulp cap - direct (excluding final restoration)	15.00	D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	140.00
D3120	Pulp cap - indirect (excluding final restoration)	10.00	D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	100.00
	PULPOTOMY		D4245	Apically positioned flap	150.00
D3220	"Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament"	35.00	D4249	Clinical crown lengthening - hard tissue	240.00
D3221	Pulpal debridement, primary and permanent teeth	95.00	D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	350.00
D3222	"Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development"	75.00	D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	203.00
	ENDODONTIC THERAPY ON PRIMARY TEETH		D4263	Bone replacement graft - retained natural tooth - first site in quadrant	450.00
D3230	"Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)"	50.00	D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	325.00
D3240	"Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)"	55.00	D4265	Biologic materials to aid in soft and osseous tissue regeneration	325.00
	ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES & FOLLOW-UP CARE)		D4266	Guided tissue regeneration - resorbable barrier, per site	325.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	130.00	D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	325.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	195.00	D4268	Surgical revision procedure, per tooth	No Charge
D3330	Endodontic therapy, molar tooth (excluding final restoration)	245.00	D4270	Pedicle soft tissue graft procedure	250.00
D3331	Treatment of root canal obstruction; non-surgical access	85.00	D4273	Autogenous connective tissue graft procedures (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	335.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	75.00	D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	125.00
D3333	Internal root repair of perforation defects	125.00	D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	502.00
	ENDODONTIC RETREATMENT				
D3346	Retreatment of previous root canal therapy - anterior	325.00			
D3347	Retreatment of previous root canal therapy - premolar	385.00			
D3348	Retreatment of previous root canal therapy - molar	460.00			
	APEXIFICATION/RECALCIFICATION PROCEDURES				
D3351	Apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	90.00			
D3352	Apexification/recalcification - interim medication replacement	90.00			

CODE	DESCRIPTION	MEMBER COPAY	CODE	DESCRIPTION	MEMBER COPAY
D4276	Combined connective tissue and double pedicle graft, per tooth	65.00	D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	245.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	215.00	D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	245.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	75.00		ADJUSTMENTS TO DENTURES	
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	299.00	D5410	Adjust complete denture - maxillary	15.00
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	392.00	D5411	Adjust complete denture - mandibular	15.00
	NON SURGICAL PERIODONTAL SERVICE		D5421	Adjust partial denture - maxillary	15.00
D4320	Provisional splinting - intracoronal	80.00	D5422	Adjust partial denture - mandibular	15.00
D4321	Provisional splinting - extracoronal	75.00		REPAIRS TO COMPLETE DENTURES	
D4341	*Periodontal scaling and root planing - four or more teeth per quadrant	50.00†	D5511	*Repair broken complete denture base, mandibular	30.00*
D4342	*Periodontal scaling and root planing - one to three teeth per quadrant	30.00†	D5512	*Repair broken complete denture base, maxillary	30.00*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	60.00†	D5520	*Replace missing or broken teeth - complete denture (each tooth)	35.00*
D4355	*Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	60.00†		REPAIRS TO COMPLETE DENTURES	
D4381	*Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	65.00†	D5611	*Repair resin partial denture base, mandibular	35.00*
	OTHER PERIODONTAL SERVICES		D5612	*Repair resin partial denture base, maxillary	35.00*
D4910	*Periodontal maintenance	40.00	D5621	*Repair cast partial framework, mandibular	35.00*
D4910	Additional Periodontal maintenance procedures	100.00	D5622	*Repair cast partial framework, maxillary	35.00*
D4920	Unscheduled dressing change (by someone other than treating dentist)	25.00	D5630	*Repair or replace broken clasp – per tooth	35.00*
D4921	Gingival irrigation - per quadrant	15.00	D5640	*Replace broken teeth - per tooth	35.00*
D4999	Unspecified periodontal procedure, by report	No Charge	D5650	*Add tooth to existing partial denture	35.00*
	COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		D5660	*Add clasp to existing partial denture – per tooth	45.00*
D5110	*Complete denture - maxillary	295.00*	D5670	*Replace all teeth and acrylic on cast metal framework (maxillary)	155.00*
D5120	*Complete denture - mandibular	350.00*	D5671	*Replace all teeth and acrylic on cast metal framework (mandibular)	155.00*
D5130	*Immediate denture – maxillary	375.00*	D5710	*Rebase complete maxillary denture	155.00*
D5140	*Immediate denture – mandibular	375.00*	D5711	*Rebase complete mandibular denture	155.00*
	PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		D5720	*Rebase maxillary partial denture	155.00*
D5211	*Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	350.00*	D5721	*Rebase mandibular partial denture	60.00*
D5212	*Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	350.00*	D5730	*Reline complete maxillary denture (chairside)	60.00*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	380.00*	D5731	*Reline complete mandibular denture (chairside)	60.00*
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	380.00*	D5740	*Reline maxillary partial denture (chairside)	60.00*
D5221	*Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	370.00*	D5741	*Reline mandibular partial denture (chairside)	85.00*
D5222	*Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	370.00*	D5750	*Reline complete maxillary denture (laboratory)	85.00*
D5223	*Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	400.00*	D5751	*Reline complete mandibular denture (laboratory)	85.00*
D5224	*Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	400.00*	D5760	*Reline maxillary partial denture (laboratory)	85.00*
D5225	*Maxillary partial denture - flexible base (including any clasps, rests and teeth)	425.00*	D5761	*Reline mandibular partial denture (laboratory)	85.00*
D5226	*Mandibular partial denture - flexible base (including any clasps, rests and teeth)	425.00*		INTERIM PROSTHESIS	
			D5810	*Interim Complete denture (maxillary)	250.00*
			D5811	*Interim complete denture (mandibular)	250.00*
			D5820	*Interim partial denture (maxillary)	175.00*
			D5821	*Interim partial denture (mandibular)	175.00*
				OTHER REMOVABLE PROSTHESIS	
			D5850	Tissue conditioning, maxillary	20.00
			D5851	Tissue conditioning, mandibular	20.00
			D5862	Precision attachment, by report	150.00
			D5899	Unspecified removable prosthodontic procedure, by report	No Charge
				NON-CLINICAL PROCEDURES	
			D5982	Surgical stent	150.00*
			D5987	Commissure splint	150.00*
			D5988	Surgical splint	150.00*
				PRE-SURGICAL SERVICES	
			D6190	Radiographic/surgical implant index, by report	235.00
				SURGICAL SERVICES	
			D6010	*Surgical placement of implant body	1050.00
			D6012	*Surgical placement of interim body for transitional prosthesis	1050.00
			D6100	Implant removal, by report	700.00
				IMPLANT SUPPORTED PROSTHETICS	
			D6056	*Prefabricated Abutment	745.00
			D6057	*Custom Abutment	595.00
			D6058	*Abutment supported porcelain/ceramic crown	795.00
			D6059	*Abutment supported porcelain fused to metal crown (high noble metal)	795.00
			D6060	*Abutment supported porcelain fused to metal crown (predominantly base metal)	795.00
			D6061	*Abutment supported porcelain fused to metal crown (noble metal)	795.00
			D6062	*Abutment supported cast metal crown (high noble metal)	795.00
			D6063	*Abutment supported cast metal crown (predominantly base metal)	795.00

CODE	DESCRIPTION	MEMBER COPAY	CODE	DESCRIPTION	MEMBER COPAY
D6064	*Abutment supported cast metal crown (noble metal)	795.00	D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	255.00
D6065	*Implant supported porcelain/ceramic crown	795.00	D6602	Retainer inlay - cast high noble metal, two surfaces	255.00
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	795.00	D6603	Retainer inlay - cast high noble metal, three or more surfaces	255.00
D6067	*Implant supported metal crown (titanium, titanium alloy, high noble metal)	795.00	D6604	Retainer inlay - cast predominantly base metal, two surfaces	255.00
D6068	*Abutment supported retainer for porcelain/ceramic FPD	795.00	D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	255.00
D6069	*Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	795.00	D6606	Retainer inlay - cast noble metal, two surfaces	255.00
D6070	*Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	795.00	D6607	Retainer inlay - cast noble metal, three or more surfaces	255.00
D6071	*Abutment supported retainer for porcelain fused to metal FPD (noble metal)	795.00	D6608	Retainer onlay - porcelain/ceramic, two surfaces	255.00
D6072	*Abutment supported retainer for cast metal FPD (high noble metal)	795.00	D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	255.00
D6073	*Abutment supported retainer for cast metal FPD (predominantly base metal)	795.00	D6610	Retainer onlay - cast high noble metal, two surfaces	255.00
D6074	*Abutment supported retainer for cast metal FPD (noble metal)	795.00	D6611	Retainer onlay - cast high noble metal, three or more surfaces	255.00
D6075	*Implant supported retainer for ceramic FPD	795.00	D6612	Retainer onlay - cast predominantly base metal, two surfaces	255.00
D6076	*Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	795.00	D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	255.00
D6077	*Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	795.00	D6614	Retainer onlay - cast noble metal, two surfaces	255.00
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	80.00	D6615	Retainer onlay - cast noble metal, three or more surfaces	255.00
D6085	Provisional implant crown	125.00	D6624	Retainer inlay - titanium	255.00
D6094	*Abutment supported crown - (titanium)	795.00	D6634	Retainer onlay - titanium	255.00
D6110	*Implant /abutment supported removable denture for edentulous arch - maxillary	1300.00	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6111	*Implant /abutment supported removable denture for edentulous arch - mandibular	1300.00	D6710	*Retainer crown - indirect resin based composite	255.00*
D6112	*Implant /abutment supported removable denture for partially edentulous arch - maxillary	1040.00	D6720	*Retainer crown - resin with high noble metal	255.00*
D6113	*Implant /abutment supported removable denture for partially edentulous arch - mandibular	1040.00	D6721	*Retainer crown - resin with predominantly base metal	255.00*
D6114	*Implant /abutment supported fixed denture for edentulous arch - maxillary	3900.00	D6722	*Retainer crown - resin with noble metal	255.00*
D6115	*Implant /abutment supported fixed denture for edentulous arch - mandibular	3900.00	D6740	*Retainer crown - porcelain/ceramic	255.00*
D6116	*Implant /abutment supported fixed denture for partially edentulous arch - maxillary	2300.00	D6750	*Retainer crown - porcelain fused to high noble metal	255.00*
D6117	*Implant /abutment supported fixed denture for partially edentulous arch - mandibular	2300.00	D6751	*Retainer crown - porcelain fused to predominantly base metal	255.00*
OTHER IMPLANT SERVICES			D6752	*Retainer crown - porcelain fused to noble metal	255.00*
D6080	Implant maintenance procedures, including removal	180.00	D6780	*Retainer crown - 3/4 cast high noble metal	255.00*
D6090	Repair implant supported prosthesis, by report	400.00	D6781	*Retainer crown - 3/4 cast predominantly base metal	255.00*
D6092	Recement implant/abutment crown	45.00	D6782	*Retainer crown - 3/4 cast noble metal	255.00*
D6093	Recement implant/abutment supported fixed partial denture	65.00	D6783	*Retainer crown - 3/4 porcelain/ceramic	255.00*
D6095	Repair implant abutment, by report	220.00	D6790	*Retainer crown - full cast high noble metal	255.00*
FIXED PARTIAL DENTURE PONTICS			D6791	*Retainer crown - full cast predominantly base metal	255.00*
D6205	*Pontic - indirect resin based composite	750.00	D6792	*Retainer crown - full cast noble metal	255.00*
D6210	*Pontic - cast high noble metal	255.00*	D6793	*Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	125.00
D6211	*Pontic - cast predominantly base metal	255.00*	D6794	*Retainer crown - titanium	255.00*
D6212	*Pontic - cast noble metal	255.00*	OTHER FIXED PARTIAL DENTURE SERVICES		
D6214	*Pontic - titanium	255.00*	D6930	Re-cement or re-bond fixed partial denture	15.00
D6240	*Pontic - porcelain fused to high noble metal	255.00*	D6940	Stress breaker	125.00
D6241	*Pontic - porcelain fused to predominantly base metal	255.00*	D6950	Precision attachment	195.00
D6242	*Pontic - porcelain fused to noble metal	255.00*	D6980	Fixed partial denture repair necessitated by restorative material failure	45.00
D6245	*Pontic - porcelain/ceramic	350.00*	EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POST OPERATIVE CARE)		
D6250	*Pontic - resin with high noble metal	250.00*	D7111	Extraction, coronal remnants - primary tooth	20.00
D6251	*Pontic - resin with predominantly base metal	255.00*	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	15.00
D6252	*Pontic - resin with noble metal	255.00*	D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	48.00
D6253	*Provisional Pontic - further treatment or completion of diagnosis necessary prior to final impression	No Charge	OTHER SURGICAL PROCEDURES		
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS			D7220	Removal of impacted tooth - soft tissue	63.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	140.00	D7230	Removal of impacted tooth - partially bony	72.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	255.00*	D7240	Removal of impacted tooth - completely bony	98.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	255.00	D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	135.00
			D7250	Removal of residual tooth roots (cutting procedure)	40.00
			D7251	Coronectomy - intentional partial tooth removal	270.00
			D7260	Oroantral fistula closure	160.00
			D7261	Primary closure of a sinus perforation	270.00

CODE	DESCRIPTION	MEMBER COPAY	CODE	DESCRIPTION	MEMBER COPAY
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50.00	D7970	Excision of hyperplastic tissue - per arch	140.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	100.00	D7971	Excision of Pericoronal Gingiva	102.00
D7280	Exposure of an unerupted tooth	85.00	D7972	Surgical reduction of fibrous tuberosity	125.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	125.00		LIMITED ORTHODONTIC TREATMENT	
D7283	Placement of device to facilitate eruption of impacted tooth	80.00	D8010	Limited orthodontic treatment of the primary dentition	1000.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	145.00	D8020	Limited orthodontic treatment of the transitional dentition	1000.00
D7286	Incisional biopsy of oral tissue-soft	95.00	D8030	Limited orthodontic treatment of the adolescent dentition	1000.00
D7287	Exfoliative cytological sample collection	75.00	D8040	Limited orthodontic treatment of the adult dentition	1350.00
D7288	Brush biopsy - transepithelial sample collection	25.00		COMPREHENSIVE ORTHODONTIC TREATMENT	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	40.00	D8070	Comprehensive orthodontic treatment of the transitional dentition	2000.00
	ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE		D8080	Comprehensive orthodontic treatment of the adolescent dentition	2000.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	40.00	D8090	Comprehensive orthodontic treatment of the adult dentition	2200.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	40.00		MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D7320	Alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant	125.00	D8210	Removable appliance therapy	103.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	60.00	D8220	Fixed appliance therapy	103.00
	VESTIBULOPLASTY			OTHER ORTHODONTIC SERVICES	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	370.00	D8660	Pre-orthodontic treatment examination to monitor growth and development	35.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	990.00	D8670	Periodic orthodontic treatment visit	No Charge
	SURGICAL EXCISION OF SOFT TISSUE LESIONS		D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	250.00
D7410	Excision of benign lesion up to 1.25 cm	25.00	D8681	Removable orthodontic retainer adjustment	No Charge
D7411	Excision of benign lesion greater than 1.25 cm	50.00	D8693	Re-cement or re-bond of fixed retainer	20.00
D7412	Excision of benign lesion, complicated	55.00	D8999	Unspecified orthodontic procedure, by report	250.00
	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS			UNCLASSIFIED TREATMENT	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	65.00	D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Charge
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	95.00	D9120	Fixed partial denture sectioning	No Charge
	EXCISION OF BONE TISSUE			ANESTHESIA	
D7471	Removal of lateral exostosis (maxilla or mandible)	95.00	D9210	Local anesthesia not in conjunction with operative or surgical procedures	No Charge
D7472	Removal of torus palatinus	95.00	D9211	Regional block anesthesia	No Charge
D7473	Removal of torus mandibularis	95.00	D9212	Trigeminal division block anesthesia	No Charge
D7485	Reduction of osseous tuberosity	95.00	D9215	Local anesthesia	No Charge
	SURGICAL INCISION		D9222	Deep sedation/general anesthesia - first 15 minutes	\$110.00
D7510	Incision and drainage of abscess - intraoral soft tissue	20.00	D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	15.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00	D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	15.00
D7520	Incision and drainage of abscess - extraoral soft tissue	20.00	D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	\$95.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00	D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	30.00
	REPAIR OF TRAUMATIC WOUNDS		D9248	Non-intravenous conscious sedation	15.00
D7910	Suture of recent small wounds up to 5 cm	35.00		DRUGS	
	OTHER REPAIR PROCEDURES		D9610	Therapeutic parenteral drug, single administration	15.00
D7921	Collection and application of autologous blood concentrate product	125.00	D9630	Drugs or medicaments dispensed in the office for home use	15.00
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	350.00		MISCELLANEOUS SERVICES	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	800.00	D9910	*Application of desensitizing medicament	20.00
D7952	Sinus augmentation via a vertical approach	350.00	D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	No Charge
D7953	Bone replacement graft for ridge preservation - per site	100.00	D9932	Cleaning and inspection of removable complete denture, maxillary	No Charge
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	110.00	D9933	Cleaning and inspection of removable complete denture, mandibular	No Charge
D7963	Frenuloplasty	105.00	D9934	Cleaning and inspection of removable partial denture, maxillary	No Charge
			D9935	Cleaning and inspection of removable partial denture, mandibular	No Charge
			D9942	Repair and/or relining of Occlusal guard	40.00
			D9943	Occlusal guard adjustment	25.00
			D9944	*Occlusal guard - hard appliance, full arch	70.00
			D9945	*Occlusal guard - soft appliance, full arch	70.00
			D9946	*Occlusal guard - hard appliance, partial arch	70.00
			D9950	Occlusion analysis - mounted case	75.00
			D9951	Occlusal adjustment - limited	30.00
			D9952	Occlusal adjustment - complete	125.00
			D9973	External bleaching - per tooth	30.00
			D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	240.00

SPECIALTY SERVICES

- 1 This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized by Solstice.
- 2 Procedures not listed on the Schedule of Benefits that are performed by a participating General Dentist will be charged at the participating General Dentist's usual and customary fee less 25%.
- 3 The participating General Dentist you select may not perform all procedures listed. The copayments shown apply to participating General Dentists. Should the services of a specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating specialist at the listed copayments. Please refer to the Specialty Care Referral Policy in your Member handbook.
- 4 Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member co-pay.
- 6 Members seeking implant treatment should refer to their participating implantologist, a select Network of Participating Providers. Not all providers perform the implant procedures at the Co-payment listed on the Schedule of Benefits. Please refer to the provider listing at www.solsticebenefits.com under "Locate A Provider."

EXCLUSIONS

- 1 Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
- 2 Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the Member's dental health or experimental in nature, as determined by the participating Solstice dentist.
- 3 Orthographic surgery or procedures and appliances for the treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
- 4 Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions, or medications.
- 5 Treatment of malignancies, cysts, or neoplasms, without proof of medical necessity and prior Solstice approval.
- 6 Dental procedures initiated prior to the Member's eligibility under this benefit plan or started after the Member's termination from the plan.
- 7 Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the Member, including but not limited to, physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

LIMITATIONS

- 1 Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; Comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation.
- 2 All bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
- 3 The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.
- 4 Fluoride (D1206, D1208, D9910) treatment is limited to one (1) in any twelve (12) consecutive month period.
- 5 Sealants (D1351 or D1352) are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
- 6 Space maintainers and all adjustments are limited to children under the age of 16.
- 7 Harmful habit appliances are limited to one (1) time per person under the age of 16.
- 8 General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice.
- 9 New dentures include one (1) reline within the first six (6) months
- 10 Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.
- 11 When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of \$30.00 per unit.
- 12 "Copayments marked by "*" do not include the cost of material and laboratory fees. Additional cost to patient is as follows:
 - High noble metal (precious) up to \$145.00
 - Titanium metal up to \$120 (covered with proof of allergy to other metals)
 - Noble metal (semi-precious) up to \$120.00
 - Predominantly base metal (non-precious) up to \$55.00
 - Crown laboratory fees up to \$155.00
 - Laboratory fees on dentures up to \$225.00
 - Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to \$65.00
 - Denture repair laboratory fees up to \$50.00
 - All ceramic and/or porcelain crown material fees up to \$155.00"
- 13 Copayments marked by "+" are not eligible at a specialist.
- 14 Either D0210, D0251, or D0330 are reimbursable one (1) time every five (5) consecutive years.
- 15 Copies of X-rays can be obtained for \$2 per periapical image up to a maximum of \$30. Panoramic X-ray can be obtained for a \$15 fee.
- 16 D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months.
- 17 All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.
- 18 Emergency treatment is available for palliative treatment for the abatement of pain up to \$100.00 per occurrence.
- 19 Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
- 20 Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.
- 21 Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
- 22 D0364-D0395 is limited to one (1) time per sixty (60) months, covered only in a dental setting and not in a radiographic imaging center.

Low PPO Plan

Solstice Low DPPO dental plan allows you and each of covered family members to use a provider of your choice; however, you'll receive a higher level of coverage when you choose a participating network provider. There is a six (6) month waiting period for Class III services (Major Services) and a twelve (12) month waiting period for Class IV (Orthodontic Services). If you use an out-of-network provider fees are subject to **Maximum Allowable Charges**. Please review the Benefit Schedule for more information.

- This plan uses the “Solstice PPO network” which is available in 52 of Florida's 67 counties, including Palm Beach, Broward, Hendry, Martin, Miami-Dade and St. Lucie counties. Solstice offers access to over 20,500 providers in Florida and has a national network that offers 135,000 providers access points nationwide. Please search for providers on www.solsticebenefits.com (Select: Product: Dental – Select a Plan: **Solstice PPO**) or contact **855-494-0098**.
- **Pre-Treatment Plans**
Both the Low PPO and High PPO dental plans cover an extensive array of dental procedures at either a fixed copayment or at a discount off the dentist's normal charges. It is highly recommended that prior to having dental work started; you request a pre-treatment plan or estimate, from your dentist on all treatment over \$300. Should you have any questions regarding your treatment plan, you can always refer to your Schedule of Benefits or call Solstice to ensure that you receive the maximum benefit from your dental plan.

Benefit	In-Network**		Out-of-Network***
Policy Year Deductible (applies to Class I, II and III)	\$50		\$100
Policy Year Maximum Benefit	\$1,000		\$500
Lifetime Orthodontic Maximum	\$1,000		\$1,000
Waiting Period Class III (Major Services) Class IV (Orthodontic Services)	6 months 12 months		6 months 12 months
Diagnostic and Preventative Services	In-Network**	Out-of-Network***	Benefit Guidelines
Periodic Oral Evaluation	100%	80%	Limited to 1 time per consecutive 6 months.
Radiographs	100%	80%	Bitewing: Limited to 1 series of films per consecutive 12 months. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Prophylaxis (Cleaning)	100%	80%	Limited to 1 time per consecutive 6 months.
Fluoride Treatment (Preventive)	100%	80%	Limited to Covered Persons under the age of 16 years, and limited to 1 time per consecutive 12 months.
Sealants	100%	80%	Limited to Covered Persons under the age of 16 years and once per first or second permanent unrestored molar every consecutive thirty-six (36) months.
Space Maintainers	100%	80%	For Covered Persons under the

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			age of 16 years.
Basic Services			
Restorations (Amalgam or Anterior Composites)*	70%	50%	Multiple restorations on one surface will be treated as a single filling. Fillings limited to once per consecutive 24 months.
Emergency Treatment	70%	50%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays.
Simple Extractions	70%	50%	Limited to 1 time per tooth per lifetime.
Major Services			
General Services	40%	20%	General Anesthesia: When clinically necessary.
Complex Oral Surgery	40%	20%	
Periodontics	40%	20%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 1 time per consecutive 3 months following active and adjunctive periodontal therapy, exclusive of gross debridement. Total number of combined periodontal maintenance procedures and dental prophylaxis services not to exceed 4 in 12 month period.
Endodontics	40%	20%	Root Canal Therapy: Limited to 1 time per consecutive 24 months.
Inlays/Onlays/Crowns*	40%	20%	Limited to 1 time per tooth per consecutive sixty 60 months.
Dentures and other Removable Prosthetics	40%	20%	Full Denture/Partial Denture: Limited to 1 per consecutive sixty 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	40%	20%	Once per tooth per consecutive sixty 60 months.
Orthodontic Services			
Diagnose or correct misalignment of teeth or bite. Child (up to age 19).	50%	25%	Course of treatment is typically 24 months, with the initial payment at banding of 20% and remaining payment spread over

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			the course of the treatment
* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$300; please consult your dentist. **The network percentage of benefits is based on the discounted fees negotiated with the provider. ***The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.			

Dental PPO Summary of Benefits Effective

1/1/2019

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	\$50	\$50	\$0	\$0
Family Annual Calendar Year Deductible	\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)	\$1000 per person per Calendar Year	\$500 per person per Calendar Year	\$1000 per person per Lifetime	\$1000 per person per Lifetime
Annual deductible applies to preventive and diagnostic services			Yes (In Network)	Yes (Out-of-Network)
Solstice BenefitsBooster Included (Increasing Calendar Year Maximum Benefit)			Yes	
Preventive Waiver Saver Included (P&D Services Do Not Accumulate Towards Annual Maximum)			No	
Orthodontic eligibility requirement			Children up to 19 Years Old	
COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES	
PREVENTIVE & DIAGNOSTIC SERVICES				
Periodic Oral Evaluation	100%	80%	Limited to two (2) times per consecutive twelve (12) months.	
Routine Radiographs	100%	80%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.	
Non-Routine - Complete Series Radiographs	100%	80%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.	
Prophylaxis (Cleanings)	100%	80%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.	
Fluoride Treatment	100%	80%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.	
Sealants	100%	80%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.	
Space Maintainers	100%	80%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.	
Palliative Treatment	100%	80%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit	
BASIC SERVICES				
Restorations (Amalgam or Composite)	70%	50%	Multiple restorations on one (1) surface will be treated as a single filling.	
Simple Extractions	70%	50%	Limited to one (1) time per tooth per lifetime.	
Anesthetics	70%	50%	General Anesthesia: When clinically necessary.	
Adjunctive Services	70%	50%		
MAJOR SERVICES				
6-Month Waiting Period				
Oral Surgery (includes surgical extractions)	40%	20%	Extractions: Limited to one (1) time per tooth per lifetime.	
Periodontics	40%	20%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area. Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.	
Endodontics	40%	20%		
Inlays/Onlays/Crowns	40%	20%	Limited to one (1) time per tooth per consecutive sixty (60) months.	
Dentures and other Removable Prosthetics	40%	20%	Full Denture/Partial Denture: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.	
Fixed Partial Dentures (Bridges)	40%	20%	Bridges: Limited to one (1) time per tooth per consecutive sixty (60) months	
ORTHODONTIC SERVICES				
12-Month Waiting Period				
Diagnose or correct misalignment of the teeth or bite	50%	25%	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.	

*The network percentage of benefits is based on the discounted fees negotiated with the provider.

**Out of-Network benefits are based on the participating provider contracted fees.

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Limitations, Non-Covered Services, and Exclusions

General Limitations

ALTERNATE BENEFIT – Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$300; please consult your dentist.

BASIC RESTORATIONS – Multiple restorations on one (1) surface will be treated as a single filling.

BITEWING RADIOGRAPHS are limited to one (1) series of films per consecutive twelve (12) months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS are limited to one (1) time per consecutive thirty-six (36) months.

DENTAL PROPHYLAXIS (CLEANINGS) are limited to

(2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.

EXTRAORAL RADIOGRAPHS are limited to two (2) films per consecutive twelve (12) months.

FLUORIDE TREATMENTS are limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.

FULL OR PARTIAL DENTURES are limited to one (1) time every consecutive sixty (60) months. No additional allowances for precision or semi-precision attachments.

FULL-MOUTH DEBRIDEMENT is limited to one (1) time per consecutive thirty-six (36) months.

GENERAL ANESTHESIA, IV SEDATION are covered when necessary for one of the following reasons; toxicity to local anesthesia, mental retardation, Alzheimer's, spastic muscle disorders.

MAJOR RESTORATIONS – Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one (1) time per consecutive sixty (60) months from initial or subsequent placement.

OCCUSAL GUARDS are limited to one (1) guard every consecutive sixty (60) months and only if prescribed to control habitual grinding.

ORAL EVALUATIONS - Periodic Oral Evaluation limited to two (2) times per consecutive twelve (12) months. Comprehensive Oral Evaluation limited to one (1) time per dentist per consecutive thirty-six (36) months, only if not in conjunction with other exams.

ORTHODONTIC SERVICES – When Orthodontic Services are covered under the plan, orthodontic services are limited to twenty-four (24) months of treatment, with the initial payment at banding of 20% and remaining payment prorated over the course of the treatment.

PALLIATIVE TREATMENT is covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

PERIODONTAL MAINTENANCE is limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and/or periodontal maintenance procedures in any twelve (12) consecutive months.

PERIODONTAL SURGERY – Hard tissue and soft tissue periodontal surgery is limited to one (1) time per quadrant or site per consecutive thirty-six (36) months.

PIN RETENTION is limited to two (2) pins per tooth; not covered in addition to Cast Restoration.

POST AND CORES are covered only for teeth that have had root canal therapy.

RELINING, REBASING AND TISSUE CONDITIONING DENTURES are limited to relining/rebasing performed more than six (6) months after the initial insertion. Thereafter, limited to one (1) time per consecutive thirty-six (36) months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES are limited to repairs or adjustments performed more than twelve (12) months after the initial insertion. Limited to one (1) time per consecutive six (6) months.

REPLACEMENT of crowns, bridges, and fixed or removable prosthetic appliances, if inserted prior to plan coverage, are covered after the patient has been eligible under the plan for twelve (12) continuous months.

REPLACEMENT of missing natural teeth lost prior to the effective date of coverage are covered only after the patient has been eligible under the plan for twelve (12), continuous months.

SEALANTS are limited to Covered Persons under the age of sixteen (16) years and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.

SCALING AND ROOT PLANING is limited to one (1) time per quadrant per consecutive twenty-four (24) months. Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth, by report, is not covered when performed on the same day as root planing and scaling.

SEDATIVE FILLINGS are covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.

SPACE MAINTAINERS are limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.

Non-Covered Services

The following are **NOT** covered under the plan:

- Dental Services that are not Reasonable and/or Necessary.
- Hospital or other facility charges.
- Reconstructive surgery to the mouth or jaw.
- Any Procedures not directly associated with dental disease.
- Any Dental Procedure not performed in a dental setting.
- Procedures that are considered Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered Experimental, Investigational or Unproven in the treatment of that particular condition.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
- Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- If previously submitted for payment under the Plan within sixty (60) months of initial or subsequent placement, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- If damage or breakage was directly related to provider error, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- Temporomandibular joint (TMJ) services; upper and lower jaw bone surgery, including that related to the TMJ; and orthognathic surgery, or jaw alignment.
- Charges for failure to keep a scheduled appointment without giving the dental office twenty-four (24) hours notice.
- Expenses for dental procedures begun before enrollment under the plan.
- Prosthodontic restoration that is fixed or removable for complete oral rehabilitation. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Attachments to conventional removable prosthesis or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Incision and drainage of abscess, if the involved tooth is extracted on the same date of service.
- Occlusal guards used as safety items or for sports-related activities.
- Placement of fixed or partial dentures for the sole purpose of achieving periodontal stability.
- Dental Services otherwise Covered under the plan but rendered after the date individual Coverage under the plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the plan terminates.
- Acupuncture, acupressure, and other forms of alternative treatment, whether or
- Services for which the Copayments and/or the Deductibles are routinely waived by the provider.
- Crowns, inlays, cast restorations, or laboratory prepared restorations when the tooth/teeth may be restored with an amalgam or composite resin filling.
- Inlays, cast restorations, or other laboratory prepared restorations when used primarily for the purpose of splinting.
- Any charges related to histological review of diagnostic biopsy, material, or specimens submitted to a pathologist or pathology lab.
- Any charges related to infection control, denture duplication, oral hygiene instructions, radiograph duplication, charges for claim submission, equipment or technology fees, exams required by a third party, personal supplies, or replacement of lost or stolen appliances.
- Any Dental Services or Procedures not listed in the Schedule of Benefits.

Exclusions

This Policy excludes Coverage for Dental Service, unless otherwise specified in the Schedule of Benefits or a Rider, as follows:

- Illness, accident, treatment or medical condition arising out of:
 - war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection;
 - service in the Armed Forces or units auxiliary thereto;
 - suicide, attempted suicide or intentionally self-inflicted injury;
 - aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and,
 - with respect to blanket insurance, interscholastic sports.
- Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Covered Person's immediate family; and services for which no charge is normally made;
- Services provided while the Covered Person is outside the United States, its possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.
- ILLEGAL OCCUPATION:** Solstice shall not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
- INTOXICANTS AND NARCOTICS:** Solstice shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

High PPO Plan

Solstice High DPPO dental plan allows you and each of covered family members to use a provider of your choice; however, you'll receive a higher level of coverage when you choose a participating Solstice network provider. There is a six (6) month waiting period for Class III services (Major Services) and a twelve (12) month waiting period for Class IV (Orthodontic Services). This plan covers Implant Services under Class III (Major Services) with a separate annual implant maximum of \$2,500 per calendar year. **If you use an out-of-network provider fees are based on 90th UCR.** Please review the Benefit Schedule for more information.

- This plan uses the "Solstice PPO network" which is available in 52 of Florida's 67 counties, including Palm Beach, Broward, Hendry, Martin, Miami-Dade and St. Lucie counties. Solstice offers access to over 20,500 providers in Florida and has a national network that offers 135,000 providers access points nationwide. Please search for providers on www.solsticebenefits.com (Select: Product: Dental – Select a Plan: **Solstice PPO**) or contact **855-494-0098**.
- Pre-Treatment Plans**
Both the Low PPO and High PPO dental plans cover an extensive array of dental procedures at either a fixed copayment or at a discount off the dentist's normal charges. It is highly recommended that prior to having dental work started; you request a pre-treatment plan or estimate, from your dentist on all treatment over \$300. Should you have any questions regarding your treatment plan, you can always refer to your Schedule of Benefits or call Solstice to ensure that you receive the maximum benefit from your dental plan

Benefit	In-Network**		Out-of-Network***
Policy Year Deductible (applies to Class I, II and III)	\$50 (does not apply to Class I)		\$100
Policy Year Maximum Benefit	\$1,500		\$1,000
Lifetime Orthodontic Maximum	\$1,500		\$1,000
Annual Implant Maximum	\$2,500 per person per Calendar Year		
Waiting Period Class III (Major Services) Class IV (Orthodontic Services)	6 months 12 months		6 months 12 months
Diagnostic and Preventative Services	In-Network**	Out-of-Network***	Benefit Guidelines
Periodic Oral Evaluation	100%	90%	Limited to 1 time per consecutive 6 months.
Radiographs	100%	90%	Bitewing: Limited to 1 series of films per consecutive 12 months. Complete/Panorex: Limited to 1 time per consecutive thirty-six 36 months.
Lab and other Diagnostic Test	100%	90%	
Prophylaxis (Cleaning)	100%	90%	Limited to 1 time per consecutive 6 months.
Fluoride Treatment (Preventive)	100%	90%	Limited to Covered Persons under the age of 16 years, and limited to 1 time per consecutive 12 months.
Sealants	100%	90%	Limited to Covered Persons under the age of 16 years, and to one (1) time per first or second unrestored

This booklet is a summary of plan provisions related to the various Group Insurance policies issues. In the event of a conflict between this summary and the applicable Group Insurance policy and/or certificate, the policy and/or certificate shall dictate the insurance and coverage provisions, exclusions, all limitations and terms of coverage. In accordance with the provisions of ADA, this document may be requested in an alternative format. If you have any questions or would like to receive additional benefit plan materials, please contact your Group Insurance office or representative.

			permanent molar every consecutive thirty-six (36) months.
Space Maintainers	100%	90%	For Covered Persons under the age of 16 years.
Basic Services			
Restorations (Amalgam or Anterior Composites)*	80%	70%	Multiple restorations on one surface will be treated as a single filling. Fillings limited to once per consecutive 24 months.
Emergency Treatment	80%	70%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays.
Simple Extractions	80%	70%	Limited to 1 time per tooth per lifetime.
Major Services			
General Services	50%	40%	General Anesthesia: When clinically necessary.
Complex Oral Surgery	50%	40%	
Periodontics	50%	40%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planning: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 1 time per consecutive 3 months following active and adjunctive periodontal therapy, exclusive of gross debridement. Total number of combined periodontal maintenance procedures and dental prophylaxis services not to exceed 4 in 12 month period.
Endodontics	50%	40%	Root Canal Therapy: Limited to 1 time per consecutive 24 months.
Inlays/Onlays/Crowns*	50%	40%	Limited to 1 time per tooth per 7 years.
Dentures and other Removable Prosthetics	50%	40%	Full Denture/Partial Denture: Limited to 1 per sixty (60) months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	50%	40%	Once per tooth per sixty (60) months.
Implants	50%	40%	Subject to separate CYM \$2500
Orthodontic Services			
Diagnose or correct misalignment of teeth or bite. Child (up to age	50%	50%	Course of treatment is typically 24 months, with the initial payment at

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19).			banding of 20% and remaining payment spread over the course of the treatment
* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$350; please consult your dentist. **The network percentage of benefits is based on the discounted fees negotiated with the provider. ***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.			

Dental PPO Summary of Benefits Effective

1/1/2019

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	\$50	\$50	\$0	\$0
Family Annual Calendar Year Deductible	\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)	\$1500 per person per Calendar Year	\$1000 per person per Calendar Year	\$1000 per person per Lifetime	\$1000 per person per Lifetime
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out-of-Network)
Solstice BenefitsBooster Included (Increasing Calendar Year Maximum Benefit)			Yes	
Preventive Waiver Saver Included (P&D Services Do Not Accumulate Towards Annual Maximum)			No	
Orthodontic eligibility requirement			Children up to 19 Years Old	
COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES	
PREVENTIVE & DIAGNOSTIC SERVICES				
Periodic Oral Evaluation	100%	90%	Limited to two (2) times per consecutive twelve (12) months.	
Routine Radiographs	100%	90%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.	
Non-Routine - Complete Series Radiographs	100%	90%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.	
Prophylaxis (Cleanings)	100%	90%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.	
Fluoride Treatment	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.	
Sealants	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.	
Space Maintainers	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.	
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BASIC SERVICES				
Restorations (Amalgam or Composite)	80%	70%	Multiple restorations on one (1) surface will be treated as a single filling.	
Simple Extractions	80%	70%	Limited to one (1) time per tooth per lifetime.	
Anesthetics	80%	70%	General Anesthesia: When clinically necessary.	
Adjunctive Services	80%	70%		
MAJOR SERVICES				
6-Month Waiting Period				
Oral Surgery (includes surgical extractions)	50%	40%	Extractions: Limited to one (1) time per tooth per lifetime.	
Periodontics	50%	40%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area. Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.	
Endodontics	50%	40%		
Inlays/Onlays/Crowns/Implants	50%	40%	Limited to one (1) time per tooth per consecutive sixty (60) months.	
Dentures and other Removable Prosthetics	50%	40%	Full Denture/Partial Denture: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.	
Fixed Partial Dentures (Bridges)	50%	40%	Bridges: Limited to one (1) time per tooth per consecutive sixty (60) months	
ORTHODONTIC SERVICES				
12-Month Waiting Period				
Diagnose or correct misalignment of the teeth or bite	50%	50%	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.	

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**Out-of-Network benefits are based on the 80th Percentile of Usual and Customary Charge.

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OCCUSAL GUARDS are limited to one (1) guard every consecutive sixty (60) months and only if prescribed to control habitual grinding.

ORAL EVALUATIONS - Periodic Oral Evaluation limited to two (2) times per consecutive twelve (12) months. Comprehensive Oral Evaluation limited to one (1) time per dentist per consecutive thirty-six (36) months, only if not in conjunction with other exams.

ORTHODONTIC SERVICES – When Orthodontic Services are covered under the plan, orthodontic services are limited to twenty-four (24) months of treatment, with the initial payment at banding of 20% and remaining payment prorated over the course of the treatment.

PALLIATIVE TREATMENT is covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

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PERIODONTAL SURGERY – Hard tissue and soft tissue periodontal surgery is limited to one (1) time per quadrant or site per consecutive thirty-six (36) months.

PIN RETENTION is limited to two (2) pins per tooth; not covered in addition to Cast Restoration.

POST AND CORES are covered only for teeth that have had root canal therapy.

RELINING, REBASING AND TISSUE CONDITIONING DENTURES are limited to relining/rebasing performed more than six (6) months after the initial insertion. Thereafter, limited to one (1) time per consecutive thirty-six (36) months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES are limited to repairs or adjustments performed more than twelve (12) months after the initial insertion. Limited to one (1) time per consecutive six (6) months.

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REPLACEMENT of missing natural teeth lost prior to the effective date of coverage are covered only after the patient has been eligible under the plan for twelve (12), continuous months.

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- Reconstructive surgery to the mouth or jaw.
- Any Procedures not directly associated with dental disease.
- Any Dental Procedure not performed in a dental setting.
- Procedures that are considered Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered Experimental, Investigational or Unproven in the treatment of that particular condition.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
- Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- If previously submitted for payment under the Plan within sixty (60) months of initial or subsequent placement, replacements of: (a) complete or partial dentures, (b) fixed bridgework, or (c) crowns. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
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- Temporomandibular joint (TMJ) services; upper and lower jaw bone surgery, including that related to the TMJ; and orthognathic surgery, or jaw alignment.
- Charges for failure to keep a scheduled appointment without giving the dental office twenty-four (24) hours notice.
- Expenses for dental procedures begun before enrollment under the plan.
- Prosthodontic restoration that is fixed or removable for complete oral rehabilitation. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Attachments to conventional removable prosthesis or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Incision and drainage of abscess, if the involved tooth is extracted on the same date of service.
- Occlusal guards used as safety items or for sports-related activities.
- Placement of fixed or partial dentures for the sole purpose of achieving periodontal stability.
- Dental Services otherwise Covered under the plan but rendered after the date individual Coverage under the plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the plan terminates.
- Acupuncture, acupressure, and other forms of alternative treatment, whether or
- Services for which the Copayments and/or the Deductibles are routinely waived by the provider.
- Crowns, inlays, cast restorations, or laboratory prepared restorations when the tooth/teeth may be restored with an amalgam or composite resin filling.
- Inlays, cast restorations, or other laboratory prepared restorations when used primarily for the purpose of splinting.
- Any charges related to histological review of diagnostic biopsy, material, or specimens submitted to a pathologist or pathology lab.
- Any charges related to infection control, denture duplication, oral hygiene instructions, radiograph duplication, charges for claim submission, equipment or technology fees, exams required by a third party, personal supplies, or replacement of lost or stolen appliances.
- Any Dental Services or Procedures not listed in the Schedule of Benefits.

Exclusions

This Policy excludes Coverage for Dental Service, unless otherwise specified in the Schedule of Benefits or a Rider, as follows:

- Illness, accident, treatment or medical condition arising out of:
 - war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection;
 - service in the Armed Forces or units auxiliary thereto;
 - suicide, attempted suicide or intentionally self-inflicted injury;
 - aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; and,
 - with respect to blanket insurance, interscholastic sports.
- Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the Covered Person's immediate family; and services for which no charge is normally made;
- Services provided while the Covered Person is outside the United States, its possessions or the countries of Canada and Mexico are not Covered unless required as an Emergency Service.
- ILLEGAL OCCUPATION:** Solstice shall not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
- INTOXICANTS AND NARCOTICS:** Solstice shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Benefits Booster

With the Benefits Booster Benefit from Solstice, you can earn award dollars for visiting the dentist at least once per year. If you have a family members covered by your plan, each family member can earn his or her own award. And you can roll your awards over from one year to the next.

How the program works:

- 1) Visit your dentist at least once during the benefit year.
- 2) At the end of the benefit year, if the dollar amount of the dental claims paid for you is less than your plan's annual claim threshold, you earn an annual account award.
- 3) If all your claims for the year were for in-network providers, you'll earn a \$100 annual network bonus.
- 4) Your annual account award will be added to your annual maximum for the following benefit year. The combined total will be the maximum benefit for the dental claims that year.

Example: Low PPO Plan - The chart below shows the award dollar you could earn if your original non-network annual maximum of \$500.

Here's how your Benefits Booster Benefit adds up:	
IF your original annual maximum is:	\$500
AND the total dental claims paid for you is one year is less than this: <i>(This is the plan's annual claim threshold.)</i>	\$250
THEN you qualify for an annual account award of:	\$125
PLUS, if all your claims for the year are for network providers, you can also earn: <i>(This is the annual network bonus.)</i>	+\$100
THEREFORE , the potential total Benefits Booster earnings for the year are: <i>(This amount is added to your annual maximum for the following year.)</i>	=\$225
Max Rollover Account Limit	\$500

Example: High PPO Plan - The chart below shows the award dollar you could earn if your original non-network annual maximum of \$1,000.

Here's how your Benefits Booster Benefit adds up:	
IF your original annual maximum is:	\$1,000
AND the total dental claims paid for you is one year is less than this: <i>(This is the plan's annual claim threshold.)</i>	\$500
THEN you qualify for an annual account award of:	\$250
PLUS, if all your claims for the year are for network providers, you can also earn: <i>(This is the annual network bonus.)</i>	+\$100
THEREFORE , the potential total Benefits Booster earnings for the year are: <i>(This amount is added to your annual maximum for the following year.)</i>	=\$350
Max Rollover Account Limit	\$1,000

BenefitsBooster terms:

- **Original annual maximum:** The maximum amount the plan will pay for a member's claim during the plan year.
- **Annual claim threshold:** A set amount determined by the plan. A member's paid claims must fall below this amount to qualify for a Benefits Booster award.

This booklet is a summary of plan provisions related to the various Group Insurance policies issues. In the event of a conflict between this summary and the applicable Group Insurance policy and/or certificate, the policy and/or certificate shall dictate the insurance and coverage provisions, exclusions, all limitations and terms of coverage. In accordance with the provisions of ADA, this document may be requested in an alternative format. If you have any questions or would like to receive additional benefit plan materials, please contact your Group Insurance office or representative.

- **Annual account award:** The dollar amount a member earns when their annual claims are greater than \$0, but lower than the annual claim threshold.
- **Annual network bonus:** The \$100 a member earns when their claims for the plan year are all for network providers.³
- **Account limit:** The maximum balance a member can have in their account.

How your awards are used:

- Your account awards are used to pay for claims that go beyond your original annual maximum.
- If you don't use your entire award balance, you can carry over the difference from year to year.
- Awards can be used for claims that you file up to 180 days after your benefit period ends.
- Awards can be used for both network and non-network claims.
- Award balances do not apply to orthodontic services or implant services.
- If you don't submit any claims during the benefit period, you won't earn any new awards.

Some things to remember:

- **If you become a member** of the Solstice plan during the last three months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in Benefits Booster.
- **If you end your benefit coverage**, but return within six months with the same employer, you can rejoin Benefits Booster without losing any previously unused award balance if your employer still offers a dental plan with Benefits Booster. However, if six months or more pass, or if your employer changes, your award balance is no longer available.
- **If your employer decides to change your dental plan**, your award balance will move with you as long as the new plan includes Benefits Booster. If the new plan does not, you will lose your award balance.

Dental Benefits at <http://www.MySolstice.net>

The information you need is all in one place. When you sign in at solsticebenefits.com, you can quickly find answers and complete important tasks 24 hours a day:

- Locate a dentist
- Review your coverage
- Check your dental claims
- Get answers to the most frequently asked questions
- Learn about oral health and dental treatment
- Request a dental ID card
- Print a temporary ID card



Solstice Member Perks

Solstice does much more than provide dental and vision benefits. We go above and beyond to offer quality holistic care to you. It's why we include the following wellness and value-added benefits along with our dental and vision plans, at no extra cost.

Experience our commitment to your overall health and wellness through the following Solstice member perks.



Wellness Programs

Prenatal Dental Care - *Additional cleanings at no additional cost*

Women in their 2nd or 3rd trimester of pregnancy can receive additional cleanings at no cost. Just let your dentist know that you're pregnant, your due date, attending doctor's name and your Solstice network provider will submit your claim.

Oral Cancer Screening - *Take advantage of a newer oral cancer screening method*

With oral cancer rates rising, regular screenings are a vital part of your dental benefits package. A newer technology has made oral cancer screening even easier and more available. Receive newer screenings at a discounted fee or at no additional cost, based on your dental plan.



Implant Services - *Pay discounted fees on 30 implant procedures*

Your smile is so important, it can even impact your job prospects. Having a discount plan that provides you with various options to address your smile is important. Save with specific member fees or discounts on 30 implant procedure codes based on your dental plan.



Pharmacy Plan - *Savings on 99% of all commonly prescribed medications*

Prescriptions, even with medical coverage, are getting expensive. With Solstice's discount drug program, get deep savings on prescriptions, even for your pets. Save on 99% of all commonly prescribed medications, through a network of over 65,000 retail pharmacies nationwide, including major retail chains and through mail service for home delivery.



Discount Vision Benefits - *Save 20% to 40% on exams, frames, lenses and contacts*

More than 11 million Americans rely on glasses or contacts to correct their vision. Solstice includes the Clear 100 Vision discount plan as part of your dental benefits package. Get discounts ranging from 20% to 40% on frames, lenses, contacts and services at a network provider.



LASIK Vision Care - *Save 15% off the standard pricing for traditional LASIK*

Considering laser vision correction? With our LASIK benefit perk, you will save 15% off the standard pricing or 5% off the promotional pricing at a network provider. Plus, receive flexible financing options – up to 12 months interest free.



Hearing Benefits - *Hearing loss affects almost 40 million Americans*

In other words, you're not alone. Solstice provides a hearing aid savings plan at no extra charge. The plan offers a complimentary hearing screening, a comprehensive exam for \$29, and savings up to 40% on retail prices on hearing aids. Get a 3-year warranty and 1-year battery supply with hearing aid purchases and a 1 year follow-up care at no cost.



Educational Member Resources - *Help understanding benefits through award-winning resources*

Do you find your benefits confusing? Does it seem like another language at times? Good news. We are passionate about helping you understand your benefits. Become a boss at understanding your coverage through our award-winning website (www.SolsticeBenefits.com). It includes our blog that addresses a wide range of dental and vision topics, our quarterly newsletter and access to helpful online resources such as your Dental Scorecard and Heathy Tips Library.



1.877.760.2247 | www.SolsticeBenefits.com

¹Centers for Disease Control and Prevention: <https://www.cdc.gov/visionhealth/data/national.htm>

Hearing care beyond compare.

Hearing Aid Savings Plan



Hearing loss affects almost 40 million Americans. In other words, you're not alone.

As a Solstice member, you have a hearing aid savings plan at no extra charge. The plan offers a complimentary hearing screening, a comprehensive exam for \$29, and savings up to 40% on retail prices on hearing aids.

Here are the advantages of the hearing aid savings plan:

- Complimentary hearing screening
- 3-year warranty and 1-year battery supply with hearing aid purchase
- 1-year follow-up care at no cost
- 10% off at www.hearingshop.com with code EARUSA

If you'd like more information, call us any time at 1.877.760.2247.
or visit our website at www.SolsticeBenefits.com.



HearUSA
America's Most Trusted Name in Hearing Care.



Solstice

Please note: this savings plan is not insurance.

Vision Care Benefits

Vision care benefits are included in both the medical plans and the dental plans.

CIGNA Vision Plan Highlights: The summary below lists vision care benefits that are available to participants in the CIGNA medical plans **through Cigna Vision**. For additional information and provider lists, call Cigna Vision at 1-877-478-7557 or visit <http://www.cigna.com>.

CIGNA Vision Plan	Network (HMO)	OAPIN	Network POS	
Benefits	In-network	In-network	In-network	Out-of-network
Eye exam - every 24 months	\$10 copay per exam	\$10 copay per exam	\$10 copay per exam	\$45 Reimbursement
	Lenses			
Single lenses	\$20 Reimbursement	\$20 Reimbursement	\$20 Reimbursement	\$20 Reimbursement
Bifocal lenses	\$30 Reimbursement	\$30 Reimbursement	\$30 Reimbursement	\$30 Reimbursement
Trifocal lenses	\$40 Reimbursement	\$40 Reimbursement	\$40 Reimbursement	\$40 Reimbursement
Lenticular lenses	\$75 Reimbursement	\$75 Reimbursement	\$75 Reimbursement	\$75 Reimbursement
	Frames and Contact Lenses			
Frames	\$30 Reimbursement	\$30 Reimbursement	\$30 Reimbursement	\$30 Reimbursement
Contact lenses – Elective	\$75 Reimbursement	\$75 Reimbursement	\$75 Reimbursement	\$75 Reimbursement
Contact lenses – Therapeutic	100%	100%	100%	\$210 Reimbursement
	Note: Reimbursement toward purchase of a pair of glasses <i>or</i> contact lenses is every 24 months			



Clear Vision 100 Discount Vision Plan

BENEFITS

Plan Highlights

Members of the Clear Vision 100 Discount Plan are eligible to receive benefits immediately upon the effective date with unlimited benefits.

The member fees listed are guaranteed to be a 20-40% discount and are offered by a participating Solstice Clear Vision product provider.

This Plan is not insurance. This Plan provides discounts at certain providers for vision services. The plan does not make payments directly to the providers of the vision service. The member is obligated to pay for all vision care services but will receive a discount from those providers who have contracted with the discount plan organization.

Solstice Benefits, Inc.
Post Office Box 19199,
Plantation, FL 33318, 877.760.2247,
a Discount Medical Plan Organization.

The patient/member is ultimately responsible for verification as to the accuracy and appropriateness of all applicable fees.

Members can choose a participating Solstice Clear Vision provider at www.SolsticeBenefits.com or contact Member Services at 877.760.2247 for a printed copy.

Benefit for contacts or frames are a once a year benefit (e.g., if a member chooses frames one year, they can choose contacts the following year).



DISCOUNT PRESCRIPTION PLAN

An added value at no cost to you.

Prescription Drug Benefit:

Now you and your family can access savings on your prescriptions at a network of over 65,000 participating local retail pharmacies or through the mail service pharmacies for home delivery of maintenance (long-term) medicines.

No Limits: Any household member may use the drug discount program any time your prescription is not covered by insurance. There are no restrictions and no limits on how many times you may use your card. Even your pet medication is included!

Save an average of 50%

on generic medication when you order by mail.

Save an average of 20%

on brand and generic medication when visiting a participating pharmacy.

The network includes national chains, local chains and independent pharmacies. You will save money on all types of prescription medications at the time of purchase. Your physician's choice of prescribed medications and your preference for brand or generic prescriptions will always be honored.

This prescription plan is not insurance. Savings are only available at participating pharmacies.



In-Network Procedures	Member Fee
Eye Exam	\$45
Lenses: • Standard Single Vision • Standard Bifocal • Standard Trifocal • Standard Progressive • Deluxe Progressive (Includes glass or plastic, dispensing fees and eyeglass case.)	\$35 \$50 \$65 \$105 20% discount
Lens Options	20% discount off of doctors usual fees
Frames	33% discount off of doctors usual fees
Contact Lenses • Fitting & Evaluation • Contact Lenses • Contact Lens Replacement (Includes care kit, insertion and removal instruction, routine follow-up/6 months)	20% discount

Life Insurance

Life Insurance provides your beneficiary with financial support upon our death, and to you upon the death of your dependent. The County provides basic group term life and accidental death and dismemberment insurance to you at no cost. You also have the option to purchase additional term life insurance for yourself, your spouse or domestic partner and/or your dependent children. Approval of additional coverage for you and your spouse or domestic partner is contingent on medical underwriting as determined by the contracted carrier.

Annual Enrollment Opportunity

Increase Additional or Dependent Term Life by one level increments of \$10,000 (Additional life) or \$5,000 (spouse life) without providing Evidence of Insurability (EOI)

- Employee coverage over \$150,000 requires EOI
- Spouse/DP coverage over \$25,000 requires EOI
- Employees or spouses previously declined for coverage must provide EOI for any coverage increase.

Please note: If EOI is required, you or your spouse/domestic partner must be approved by the carrier for coverage to become effective.

Protect your family's financial future

Enroll in your group life insurance plan





Guaranteed coverage options

The following coverage options are available to elect without providing evidence of insurability (EOI):

Within 31 days of initial eligibility:

- **Employee:** Elect up to \$150,000
- **Spouse/domestic partner DP:** Elect up to \$25,000
- **Child:** All guaranteed

During each annual enrollment:

- **Employee:** Enroll or increase by \$10,000 as long as the resulting total does not exceed \$150,000
- **Spouse/DP:** Enroll or increase by \$5,000 as long as the resulting total does not exceed \$25,000
- **Child:** All guaranteed

Within 31 days of a qualified family status change:

- **Employee:** Enroll or increase by \$10,000 as long as the resulting total does not exceed \$150,000
- **Child:** All guaranteed

Elections made outside of these periods and elections exceeding these amounts require EOI. Applicants previously declined coverage must also provide EOI.

Why do I need life insurance?

Group term life insurance provides cost-effective insurance protection during your working years. It provides an additional level of financial protection alongside your personal savings, individual life insurance and Social Security benefits. Group term life insurance allows you the flexibility to increase your coverage when your family's need for financial protection is the greatest and to lower your coverage when your financial commitments decrease.

Beneficiaries receive funds to help with their everyday living expenses — such as mortgage payments or medical bills — education expenses, your funeral costs and more.

Your family is everything — and group term life insurance can help protect their financial future so you can enjoy everyday moments in the here and now.

Accidental death and dismemberment (AD&D)

insurance provides additional financial protection should you or your spouse die or become dismembered due to a covered accident — whether it occurs at work or elsewhere.

Your basic and optional coverages

Basic coverage (automatically enrolled)

✓	Basic term life and AD&D	\$25,000 life \$15,000 AD&D	• Coverage reduces to 50 percent at age 70
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Optional coverages

+	Additional term life and AD&D	\$10,000 increments	• Maximum coverage: \$300,000 • Includes matching AD&D benefit
+	Spouse/domestic partner (DP) term life and AD&D	\$5,000 increments	• Maximum coverage: \$50,000 • Spouse/DP and child coverages may not exceed 100% of the employee's total life insurance amount • Includes matching AD&D benefit
+	Child term life	\$5,000 or \$10,000	• Children eligible from live birth to the end of the calendar year of their 25th birthday • Spouse/DP and child coverages may not exceed 100% of the employee's total life insurance amount

If your spouse/domestic partner or child is an eligible employee under the plan, they cannot be covered as a dependent. Only one employee may cover a dependent child.

Take your coverage with you

If you are no longer eligible for coverage as an active employee, you may be eligible to port your group life insurance coverage or you may convert your life coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.



Why life insurance?

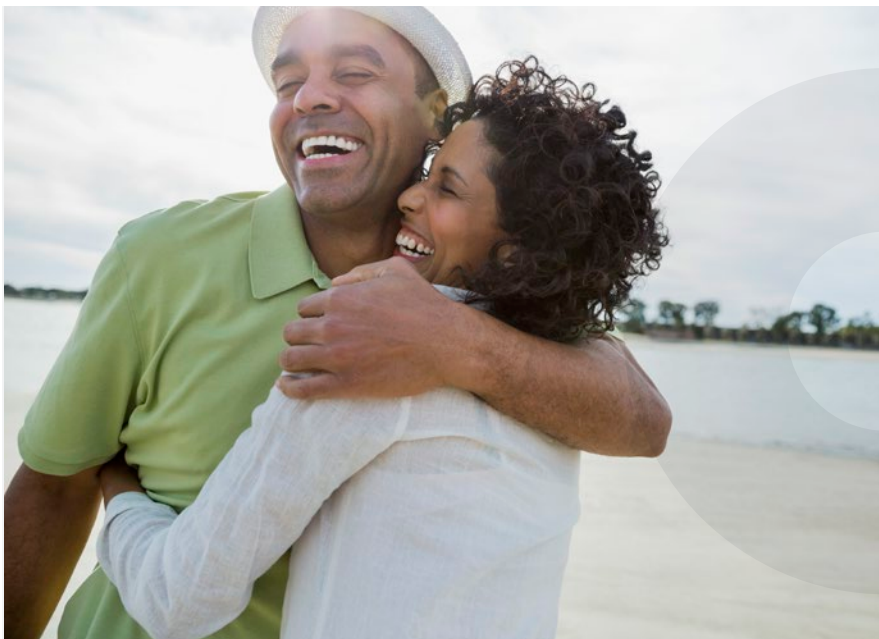
Learn how life insurance can protect your financial future by watching a brief video at LifeBenefits.com/videos/term

Enroll

Access your group enrollment system, MyBenefits, to enroll

Questions?

Contact risk management/group insurance: **561-233-5400** or email: bccmybenefits@pbcgov.org



Bi-weekly cost of coverage

Please note, rates increase with age.

Additional employee term life and AD&D	
Coverage amount	Deduction
\$10,000	\$1.68
20,000	3.36
30,000	5.04
40,000	6.72
50,000	8.40
60,000	10.08
70,000	11.76
80,000	13.44
90,000	15.12
100,000	16.80
110,000	18.48
120,000	20.16
130,000	21.84
140,000	23.52
150,000	25.20
160,000	26.88
170,000	28.56
180,000	30.24
190,000	31.92
200,000	33.60
210,000	35.28
220,000	36.96
230,000	38.64
240,000	40.32
250,000	42.00
260,000	43.68
270,000	45.36
280,000	47.04
290,000	48.72
300,000	50.40

Spouse/Domestic partner term life and AD&D	
Coverage amount	Deduction
\$5,000	\$0.84
10,000	1.68
15,000	2.52
20,000	3.36
25,000	4.20
30,000	5.04
35,000	5.88
40,000	6.72
45,000	7.56
50,000	8.40

Child term life	
Coverage amount	Deduction
\$5,000	\$0.17
10,000	0.34

All rates are subject to change.

Here's the easy math to your bi-weekly premium:

Total coverage
you need \$ _____

÷ 1,000 \$ _____

× your rate \$ _____

=

Bi-weekly premium \$ _____

How much life insurance do I need?

Check out our life insurance calculator at
LifeBenefits.com/insuranceneeds

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life Insurance Company to Palm Beach County. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage. All elections or increases are subject to the actively at work requirement of the policy.

Insurance products are underwritten by Minnesota Life Insurance Company. Products offered under policy form series MHC-96-13180.9.

Insurance products are issued by Minnesota Life Insurance Company or Securian Life Insurance Company, a New York authorized insurer. Minnesota Life is not an authorized New York insurer and does not do insurance business in New York. Both companies are headquartered in St. Paul, MN. Product availability and features may vary by state. Each insurer is solely responsible for the financial obligations under the policies or contracts it issues.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its affiliates.



lifebenefits.com

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Disability Insurance

Disability insurance provides income if you are unable to work due to a disabling non-work related sickness or injury. The County provides Short-term and Long-term Disability Insurance through CIGNA. Evidence of Insurability may be required. Approval of coverage may be contingent on medical underwriting as determined by the contracted carrier.

LATE ENROLLMENT - Approval may be contingent on medical underwriting

You will be required to successfully complete Evidence of Insurability (EOI) and must be approved by the carrier for coverage to become effective if you:

- did not enroll in the STD coverage when you became eligible (as of plan year 2011) and wish to elect STD coverage thereafter
- are currently enrolled in the Core LTD coverage and wish to upgrade to the Buy-Up/Voluntary coverage
- are not currently enrolled in the Core LTD coverage and wish to elect the Buy-Up/Voluntary coverage

Short Term Disability (STD)

This voluntary plan is designed to cover any gap in your existing sick leave accumulation until you recover or become eligible for Long-Term Disability (if enrolled)

Short Term Disability Insurance – CIGNA Group Insurance

EE Only - Weekly benefit is 67% of gross/max \$1200/week. **100% employee paid**
\$15.75 - Bi-weekly Rate

- Eligibility: Must be an active employee working 30 hours or more per week
- Employees who did not enroll in this benefit when it became available (Plan Year 2011) will be required to successfully complete Evidence of Insurability (EOI) and must be approved by the carrier for coverage to become effective
- Benefit amount – 67% of your earnings reduced by deductible income
 - Maximum weekly benefit: \$1,200
 - Minimum weekly benefit: \$100
- Coverage period of either 11 weeks or until you no longer qualify whichever occurs first, following the initial 14 days of continuous disability
- Please note a typical maternity leave benefit is payable for six (6) to eight (8) weeks - depending on the type of delivery - and is reduced by the 14 day waiting period
- Sick leave and Workers' Compensation offset the benefit – vacation pay does not
- If chosen, benefit is paid entirely by the employee on a post-tax payroll deduction basis
 - **Cost: \$15.75 bi-weekly; \$31.50 monthly**
- Active Work Requirement: If you are incapable of Active Work because of Physical Disease, Injury, Pregnancy or Mental Disorder on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible member
- **Note:** If you are a worker of the CWA bargaining unit, please review your contract. The CWA offers its own short term disability benefit program separate and apart from this plan, which is considered deductible income under this plan. Please contact your union representative with questions regarding short term disability benefits available to you under the CWA contract

Long Term Disability (LTD)

The County provides a basic or “Core” disability plan to you at no cost, provided you are enrolled in the HMO or OAPIN medical plan. Employees have the option to purchase additional long-term disability coverage.

This booklet is a summary of plan provisions related to the various Group Insurance policies issues. In the event of a conflict between this summary and the applicable Group Insurance policy and/or certificate, the policy and/or certificate shall dictate the insurance and coverage provisions, exclusions, all limitations and terms of coverage. In accordance with the provisions of ADA, this document may be requested in an alternative format. If you have any questions or would like to receive additional benefit plan materials, please contact your Group Insurance office or representative.

Long Term Disability Insurance – CIGNA Group Insurance

- **Free Basic LTD** – EE Only – must have HMO or OAPIN medical plan. Monthly benefit is 50% of monthly gross/max \$1000/month. ***100% Employer paid.**
- **Voluntary /Buy-Up LTD** – EE Only - Monthly benefit is 60% of monthly gross / max \$5000/month. **100% employee paid.** Cost is based on salary. Use formula to calculate rate:
 - Employee with HMO/OAPIN: Annual salary ÷ 12 months x .0045 = \$4.60 = monthly ÷ 2 = bi-weekly rate
 - Employee without HMO/OAPIN: Annual salary ÷ 12 months x .0058 = monthly ÷ 2 = bi-weekly rate

Example: Employee with HMO plan @ \$30,000/yr will pay \$3.25 bi-weekly ♦ Employee with POS/Opt-Out @ \$30,000 will pay \$7.25 bi-weekly

- Key Features:
 - Duration of Benefit: To age 65, if age 59 or under at commencement of disability; a different schedule applies to disabilities commencing at or after age 60
 - Elimination Period: 90 days from date of total disability
 - Conditions Insured: Accident and Sickness
- Benefit Reductions - Benefits are reduced with Social Security, Workers' Compensation, any disability or retirement benefit you receive or are eligible to receive under your employer's retirement plan, or other group disability benefits you may have (review Certificate for complete list)
- Partial Benefits - If you return to work part-time (after qualifying for benefits) and suffer more than a 20% loss of income, a partial benefit will be paid
- Pre-existing Exclusions - If disability occurs within the first 12 months of your coverage and is related to a condition that you received treatment for or took prescribed medication in the 3 months prior to your effective date, the disability is not covered
- Definition of Disability: Two years in your "own occupation", then any occupation thereafter which you are reasonably suited for by training, education or experience
- Evidence of Insurability (EOI) will be required to upgrade from the Core plan.
- Visit **www.CIGNA.com/DIAM** to access the Disability Income Needs Calculator (Consumer Toolkit section) and other information about disability insurance.

Core/Free Basic LTD Plan (included with the Network HMO or OAPIN Health Plans)

- This benefit is intended to protect employees who are disabled for over 90 days and unable to return to work because of a covered disability
- The benefit offers HMO and OAPIN health plan participants a maximum monthly benefit of **up to \$1,000** (\$100 minimum monthly benefit)
- This benefit is offered at no cost to the employee and is available only to employees who participate in the **CIGNA HMO health plan or OAPIN health plan** through BCC
- Benefits Payable: 50% of your monthly gross salary to a maximum \$1,000 monthly benefit
- You can increase the percentage of your monthly benefit amount to 60% of your monthly covered earnings and your maximum monthly benefit to \$5,000 by purchasing additional protection with the voluntary or Buy-up LTD plan

Voluntary/Buy-up LTD Plan

- This optional level allows you to **increase** the percentage of your monthly benefit amount to 60% of your monthly covered earnings and your maximum monthly benefit to \$5,000

- Participants who are participating in either the CIGNA HMO or OAPIN health plan will receive credit for the value of the Core plan when electing the Buy-Up LTD plan
- Benefits Payable: 60% of your monthly gross salary to a maximum \$5,000 monthly benefit 5,000 (\$100 minimum monthly benefit)

HOW TO REPORT A DISABILITY CLAIM

How do I report a disability claim?

Simply do one of the following:

- Call toll-free **800.36.Cigna (24462)** or **866.562.8421** (Español) between 7:00 am and 7:00 pm CST. A representative will walk you through the process.
- Fill out a claim form online at **Cigna.com/customer-forms** using the following steps:
 - Click "Select Disability/Accident/Life/Critical Illness Forms"
 - Click "Submit a Disability Claim"
 - This will bring you to the disclosure notice page
 - Review and click "Continue" at the bottom of the page
 - A pop up box will appear that says "Hit the continue button if you have read the above fraud language and wish to continue to file a claim"
 - Click "Continue"
 - Click "Submit a Disability Claim Online" to begin

When do I report a claim?

- Contact your employer on or before your first day out of work. Tell them when and for how long you plan to be absent.
- If you know you'll be out for more than seven days in a row, call Cigna at **800.36.Cigna (24462)** or **866.562.8421** (Español). Make sure you call us before your seventh day out of work so we can begin reviewing your claim. If your plan allows for coverage sooner than seven days, you should report your claim promptly.

What information do I need?

Before you call or go online, please have this information handy:

- Your name, address, phone number, birth date, Social Security number and email address

- Employment information, such as date hired and job title
- Reason for your claim – illness, injury or pregnancy
- Description of your illness, symptoms and/or diagnosis. Include the date your symptoms first appeared and if you have had these symptoms before
- Workers' compensation claims you've filed or plan to file
- Details about doctor, hospital or clinic visits, including dates and contact information

What happens next?

During the call, we'll ask for your permission to get your medical information. Here's how it works:

- After you give us your claim information, you'll be transferred to a recorded message

continued on the next page

If you need immediate medical attention, please call 911

Cut and carry for easy reference

How to report a disability claim: 800.36.Cigna (24462) or 866.562.8421 (Español)
Visit: Cigna.com/customer-forms

Please have this information handy:

- Your name, address, phone number, birth date, Social Security number and your date of hire, employer's name, address and phone number
- Date of your claim and when you plan to return to work. If you're pregnant, give your expected delivery date
- Name, address and phone number of each doctor you are seeing for this absence

Together, all the way.®



- › Listen to the recording and answer “Yes” or “No” to the questions
- › At the end of the recording, say “Yes” if you give permission or “No” if you do not
- › You can cancel your permission at any time by calling your Cigna claim manager

After the call, Cigna will send you a letter. It'll include a copy of the recorded message for your records. It'll also include a form that gives us permission to get other information we may need to finish processing your claim. Please sign and return that form. Check with your doctor to see if there are any other forms you need to sign.

A Cigna claim manager will call you and your employer for a list of your job requirements. The claim manager will also call your doctor for your medical records. This information will help us figure out how long you may be out of work, and the benefits you may be able to receive.

What happens if my claim is approved?

- › Cigna will send you an approval letter that gives you an explanation of your benefits. You may also get a recorded call from Cigna with this information.
- › Cigna will coordinate payment of your benefits as soon as possible.
- › Cigna will tell your employer that we approved your claim, and the date you plan to return to work.

What happens if my claim is denied?

- › Cigna will send you a letter that explains why. The letter will also tell you how you can appeal the decision.
- › Cigna will let your employer know the claim is denied.
- › You should call your employer when you get the letter to discuss your return-to-work date.

What can I expect while I'm out?

Your Cigna claim manager will stay in touch to help you return to work quickly and safely. We may work with you, your doctor and your employer to talk about different work options. This may include an adjustment to your job or work schedule. Your employer may also call you to check on your progress and offer support.

What if I can't return to work on the date my disability benefits end?

- › Call your Cigna claim manager to talk about the situation and learn about your options.
- › Call your employer to let them know when you plan to return to work.

What should I do when it's time to return to work?

Call your employer and Cigna claim manager to let them know the date you'll be returning to work.

What if I need more information?

Cigna has a website that provides useful information for you and your family members – from submitting a disability claim and what comes next, to information that can help you manage a specific condition at work, and even how to access valuable programs offered with your plan at no additional cost to you. Please visit the website at **Cigna.com/workwellness**.

Questions?

Call **800.36.Cigna (24462)** or **866.562.8421** (Español). A Cigna representative is available to help you between 8:00 am and 5:00 pm CST.



CIGNA IDENTITY THEFT PROGRAM



Your identity cannot be replicated, but it can be stolen.

Identity Theft occurs when someone uses your personal identifying information, like your name, Social Security number, or credit card number, without your permission, to commit fraud or other crimes. It's America's fastest growing crime, victimizing about 12.7 million people in 2014.* Cigna's Identity Theft program is available to help if this serious crime impacts you.

Valuable help before and after identity theft.

Our identity theft program provides tools and guidance to help with prevention, detection and resolution.

This includes:

- Education on how to identify and avoid identity theft before it happens
- An identity theft protection kit that provides the right documents to use and steps to follow if your identity has been compromised
- Help to complete an identity theft affidavit and cancel lost credit cards
- Guidance to help you replace credit cards, a driver's license, Social Security card, passport, etc.
- Assistance with understanding your credit reports to determine if identity theft has occurred, and help with reporting an identity theft to credit reporting agencies
- Help with emergencies while traveling, including translation services with local authorities, filing a police report, and emergency message relay
- Up to \$1,000 cash advance if your wallet or purse is stolen when traveling more than 100 miles from home**

Not sure how to get started?

If you become a victim of identity theft, Cigna's program is here for you.

- Get assistance with credit card fraud, and financial or medical identity theft
- Receive real-time, one-on-one assistance – 24 hours a day, 365 days a year – no matter where you are in the world***
- You'll have unlimited access to our personal case managers until your problem is resolved

If you suspect you might be a victim of identity theft, call 1.888.226.4567 (U.S. and Canada) or 202.331.7635. Personal case managers are standing by to help you. Please indicate that you are a member of the Cigna identity theft program and group #57.



* Javelin Strategy and Research, March, 2014.

** When the theft occurs 100 miles or more from primary residence. Must be secured by a valid credit card and repaid by customer within 30 days, or fees/charges will apply.

*** Assistance with U.S. bank accounts only.

Together, all the way.®



Offered by: Connecticut General Life Insurance Company, Life Insurance Company of North America or Cigna Life Insurance Company of New York.

Cigna Identity Theft Program services are provided under a contract with Generali Global Assistance. Presented here are highlights of the identity theft program. Full terms, conditions and exclusions are contained in applicable service agreement. **This program is NOT insurance and does not provide for reimbursement of financial losses.**

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Connecticut General Life Insurance Company, Life Insurance Company of North America, and Cigna Life Insurance Company of New York. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

WILL PREPARATION



Plan for your family's future and financial well-being.

Sixty-four percent of Americans do not have a will.* That means that they have little or no control over decisions after they die. It also leaves a burden on family members. They must make hard choices at an emotional time. Advance planning helps to make the process easier. And Cigna's Will Center can help you with the planning process.

Getting started is easy

Go to **CignaWillCenter.com**. It's easy to use and available to you and your spouse anytime day or night. Once you're registered on the site, you can:

- › **Get resources and tools to help you plan** and learn more about:
 - Will preparation
 - Estate planning
 - Funeral planning
- › Create a central location to store important information for easy access
- › **Create state-specific, legal documents online**, including:
 - Last will and testament
 - Living will
 - Financial power of attorney
 - Power of attorney for health care
 - Medical treatment authorization for minors

› Manage your legal documents. You can:

- Preview
- Edit
- Download
- Print



Service representatives are available to help you at **1.800.901.7534****



Visit **CignaWillCenter.com** today.

For help, call **800.901.7534.****

Representatives are available between 7:00 AM and 7:00 PM (CST).

Or you can email a help request to **Service@ARAGdirect.com**.

*"Perspectives on Wills," conducted by ARAG, April 2013

** No legal advice is provided

Together, all the way.SM



Registrations and customized documents are maintained for two years, which allows individuals to easily make revisions to their legal documents as their personal situation changes.

Will preparation services are independently administered by ARAG®. Cigna does not provide legal services and makes no representations or warranties as to the quality of the information on the ARAG website or the services of ARAG.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Life Insurance Company of North America, Cigna Life Insurance Company of New York, and Connecticut General Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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Flexible Benefits Plan

The County's Flexible Benefits plan is administered by the P&A Group. Flexible benefits include IRS tax-favored flexible spending accounts (FSA's/FLEX). Flexible Spending Accounts allow you to use before-tax dollars to pay for out-of-pocket eligible health care and dependent care expenses incurred during the plan year. You never pay federal income or Social Security taxes on this money. Every dollar you contribute is **pre-tax**, *reducing your taxable income and increasing your take-home pay!*

<i>FLEXIBLE SPENDING ACCOUNTS – P & A Administrative Services, Inc. -</i>
• Healthcare FSA contributions: \$260 min - \$2,700 max annually or \$10.00 - \$103.85 bi-weekly • Dependent Care FSA contributions: \$260 min - \$5,000 max annually or \$10.00 min – \$192.31 bi-weekly

County of Palm Beach

FSA Rules to Remember

Plan Year

1/1/2020 - 12/31/2020

Grace Period

A provision that gives you two and a half months after the end of the plan year to incur eligible expenses, as long as you are actively enrolled as of the last day of the plan year. Participants have until March 15, 2021 to incur expenses during the plan year.

Run-Out Period

Participants have until April 30, 2021 to submit for expenses incurred during the plan year and grace period.

Use or Lose Rule

Unused account balances will not rollover. Remember, only contribute money you are confident you will use to pay for qualified expenses during the plan year and grace period.



WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) allows you to set aside a portion of your pay pre-tax to use for medical, dental, vision, and child care/elder care expenses that are not covered by insurance, or only partially covered. Because it is deducted from your pay before taxes, you can save up to 30% on your dollar (depending on your tax bracket)! Estimate how much you usually spend on these types of expenses in a year and set aside that dollar amount into your FSA.

ACCOUNTS AVAILABLE

Health FSA

Covers the cost of medical, dental, and vision expenses incurred by you and or your eligible dependent(s). Eligible expenses include deductibles, co-pays, prescriptions, eyeglasses, and dental work.

Min. annual election amount: \$260 | Max. annual election amount: \$2,700

Dependent Care/Daycare Assistance Account

Covers the amount you pay to daycare centers, babysitters, after school programs, day camp programs and eldercare facilities. *This account does NOT reimburse medical expenses for your dependent(s). It is for qualified daycare expenses only.*

Maximum election amount: \$5,000

ELIGIBILITY NOTE: *Should you become ineligible for this benefit and still have money credited to a Flexible Spending Account when eligibility is lost, the remaining account balance may be used to reimburse you for eligible expenses you had before you lost eligibility. Remaining claims must be submitted within 30 days after you lost eligibility. Health FSA Accounts will be considered for COBRA coverage should your account still have a balance at the time of the qualifying event.*

FLEXIBLE SPENDING ACCOUNT

P&A BENEFITS CARD

Your employer offers a Benefits MasterCard for employees who participate in the plan. The Benefits MasterCard works like a debit card. When you incur an eligible expense present your Benefits Card to the provider of the goods or services you are purchasing. Swipe your card at the point-of-service and the expense will automatically be deducted from your FSA balance. If you are unable to use your Benefits Card, you can still be reimbursed for all eligible expenses. Save your receipt and submit a claim to P&A Group using one of the methods below. For all purchases, we encourage you to save your receipts in case documentation is requested. NOTE: This card cannot be used at an ATM machine to withdraw cash.

Your debit card is valid for three years from the date of issue. If this is your third year enrolling with P&A Group, you may be receiving a new benefits card in the mail. When it is time for you to receive a new card your card will automatically be mailed to your home address in a plain white envelope.



NOTE: You do not need to be enrolled in your company's health insurance plan in order to participate in the FSA.

Mobile App

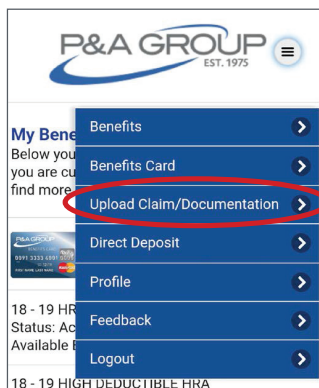
Manage your account through our mobile app. Go to the App Store or Google Play and search "P&A Group" to download it today!



4 WAYS TO SUBMIT YOUR CLAIMS

NEW P&A Group Mobile App

Download our mobile app and log into your account. Go to the menu and tap Upload Claim/Documentation to submit your claims.



QuikClaim from Your Smartphone

Capture a picture of your receipt or other supporting documentation of your eligible expense. Log into your P&A Account at www.padmin.com from your mobile device by selecting Account Login and follow the prompts on your screen.

Electronic Claim Upload from Your Computer

Submit claims directly online at P&A's website www.padmin.com by logging into your P&A account. Select Upload Claim/Documentation under Member Tools.

Fax or Mail a Paper Claim

Complete a claim form and fax or mail it to P&A Group. Claim forms are available when you log into your account at www.padmin.com.

FAX: (877) 855-7105

MAIL: P&A Group 17 Court St. Ste 500 Buffalo, NY 14202

When submitting a claim make sure to include proof of service/documentation (itemized receipt, etc).

FSA CALCULATOR

Use this online tool to help estimate your calculated savings when you sign up for an FSA. Log into your account at www.padmin.com to access the calculator or go to www.padmin.com, select **Benefit Programs**, then **Tools & Resources**.

QUESTIONS?

Customer service hours are M - F, 8:30 am - 10:00 pm ET.

PH: (800) 688-2611

WEB: www.padmin.com

MAIL: 17 Court Street

Suite 500

Buffalo, NY 14202

End of Coverage

All coverage ends at midnight on the last day of the month in which you terminate employment. For example if the last day you work is May 1st, your coverage ends at midnight on May 31st. If the last day you work is May 30th, your coverage ends as of midnight on May 31st.

If an employee ends coverage or resigns, retires or terminates employment, existing and paid coverage will continue until the end of the month in which an employee terminates. Deductions will stop the first full pay period following the coverage end date for coverage termination and employment separation. Accordingly, deductions usually will be applied to any checks as long as the employee has coverage for all or some of the pay period for which the paycheck is processed.

Continuation Group Health Coverage

As provided by The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you and/or your eligible dependents may continue participation in the County's group medical and/or dental plans. Please refer to the COBRA notice included in this summary.

Retiree Insurance – Continuation of Coverage for Retirees

Florida Law (112.0801) requires that Palm Beach County makes available to retirees the same medical and dental plan benefits that active employees have. As a retiree, you are eligible to participate in the medical and dental plan and to purchase group term life insurance provided you pay the full cost of the premiums.

Life Insurance portability/conversion

Employees who were previously insured for Basic and Additional Term Life Insurance coverage may elect to continue their in-force insurance, as well as any in-force insurance on their dependents. Employee must apply for portability from the carrier within 31 days from the date coverage would otherwise terminate.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY
BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS
INFORMATION, PLEASE REVIEW IT CAREFULLY.**

This notice is provided to you on behalf of the Palm Beach County Board of County Commissioners and participating agencies Palm Tran, Inc. and Supervisor of Elections, and applies to the privacy practices of the BOCC covered health plans (the Plan). It is intended to satisfy the notice requirements under the Health Insurance Portability and Accountability Act of 1996, amended by the HITECH Act of American Recovery and Reinvestment Act of 2009 (HIPAA). The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
 - the Plan's legal duties with respect to your PHI;
 - your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to the Plan Administrator(s) for purposes related to treatment, payment and health care operations. The plan documents provide for the protection of your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Plan does not use or disclose PHI that is genetic information for underwriting purposes.

Uses and disclosures that require your consent

If you decline to provide consent for the use of your PHI for treatment, payment and health care operations you will not be enrolled in the Plan.

Uses and disclosures that require your written authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes, drug and alcohol addiction treatment records, and HIV status about you from your health care practitioner. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include

summary information about your mental health treatment.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which consent authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.
2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

- reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
 5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
 6. When required for law enforcement purposes (for example, to report certain types of wounds).
 7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
 8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
 9. The Plan may use or disclose PHI for research, subject to conditions.
 10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
12. We may use or disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ bank as necessary to facilitate organ or tissue donation or transplantation.
13. We may disclose your PHI of armed forces personnel if authorized by military command authorities. We may also disclose your PHI to authorized federal officers for conducting national security, intelligence and counterintelligence activities.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to: Scott Marting, Director of Risk Management, 100 Australian Avenue, West Palm Beach, Florida 33406, (561) 233-5400.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to: Scott Marting, Director of Risk Management, 100 Australian Avenue, West Palm Beach, Florida 33406, (561) 233-5400.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to: Scott Marting, Director of Risk Management, 100 Australian Avenue, West Palm Beach, Florida 33406, (561) 233-5400).

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact: Scott Marting, Director of Risk Management, 100 Australian Avenue, West Palm Beach, Florida 33406, (561) 233-5400.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child. The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Right to Request Confidential Communications

You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to:

Scott Marting
Director of Risk Management
100 Australian Avenue

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

West Palm Beach, Florida 33406

The Plan will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests.

Right to Be Notified of a Breach

You have the right to be notified in the event that we or a Business Associate discover a breach of unsecured PHI, in accordance with our breach investigation procedures.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 13, 2003, and is amended and restated effective April 1, 2011, and further amended and restated September 23, 2013, and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to

accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy officer: Nancy Bolton, Assistant County Administrator, 301 N Olive Ave, West Palm Beach, Florida

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

33401, (561) 233-2030. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: Scott Marting, Director of Risk Management, 100 Australian Avenue, West Palm Beach, Florida 33406, (561) 233-5400.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

Questions

If you have any questions about this notice, please contact Palm Beach County's Privacy Officer:

Nancy Bolton,
Assistant County Administrator
301 N Olive Ave
West Palm Beach, FL 33401
Phone: (561) 233-2030
nbolton@pbcgov.org

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/cohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.cohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

IMPORTANT GENERAL NOTICE OF COBRA CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS

To: Covered Employee, Spouse, and Dependent Children of Employee

INTRODUCTION

This is for informational purposes only. You are receiving this notice because you have recently gained coverage under one or more group health plans sponsored by PALM BEACH CTY BOARD OF CTY COMM ("the Plan"). The following information about your rights and obligations under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) is very important. Both you and your spouse (if covered) should read this summary of rights very carefully, retain it with other Plan documents, and refer to it in the event that any action is required on your part.

COBRA requires that most employers providing group health plans offer participants and/or their covered family members the opportunity for a temporary extension of group health plan coverage ("COBRA coverage") at group rates under certain circumstances when coverage under the Plan would otherwise end. COBRA (and the description of COBRA coverage contained in this notice) generally applies only to the group health plan benefits offered under the Plan and not to any other benefits (e.g., life insurance).

This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it. This notice does not fully describe COBRA coverage or other rights under the Plan. You will find a more detailed summary of your rights and obligations under COBRA in the applicable group health plan summary plan description (SPD). For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's SPD, contact the Plan Administrator identified in that SPD, or you can contact CONEXIS, who assists the Plan Administrator with COBRA administration.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace ("the Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options at www.HealthCare.gov. In addition, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

COBRA COVERAGE

COBRA coverage is continuation of Plan coverage by *qualified beneficiaries* who lose coverage as a result of certain *qualifying events* (described below). After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to individuals who lose Plan coverage and are *qualified beneficiaries*.

A *qualified beneficiary* is any of the following who are covered under the Plan on the day before a qualifying event: (1) a covered employee, (2) a covered spouse of a covered employee (including a retired employee), and/or (3) a covered dependent child. In addition, a child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary if enrolled in accordance with the terms of the Plan.

You do not have to show that you are insurable to elect COBRA coverage. Under the Plan, however, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage. Generally, you will have to pay the "applicable premium" (as defined in COBRA) plus a 2 percent administrative fee for your COBRA coverage (and possibly a 50 percent administrative fee during the 11-month disability extension [see "Disability Extension of COBRA Coverage," below]). The "applicable premium" is the total cost of coverage without regard to any employer contributions, as determined in accordance with COBRA. The first COBRA premium is due 45 days after the date that you make your COBRA coverage election. All subsequent premiums are due the first day of each month with a 30-day grace period by which a complete premium must be made.

The law also requires that, at the end of the 18-, 29-, or 36-month COBRA coverage period, you must be allowed to enroll in an individual conversion health plan provided under the current group health plan, if the plan provides a conversion privilege.

QUALIFYING EVENTS

If you are a covered employee, you may elect COBRA coverage if you lose coverage under the Plan because of either one of the following qualifying events: (1) your hours of employment are reduced; or (2) your employment ends for any reason (other than gross misconduct on your part).

If you are the covered spouse of a covered employee (including a retired employee), you may elect COBRA coverage if you lose coverage under the Plan because of any of the following qualifying events: (1) the covered employee's hours of employment are reduced; (2) the covered employee's employment ends for any reason (other than his or her gross misconduct); (3) the covered employee dies; (4) the covered employee becomes entitled to Medicare benefits under Part A, Part B, or both; or (5) you and the covered employee divorce or legally separate.

For a covered dependent child of the covered employee, he or she may elect COBRA coverage if he or she loses coverage under the Plan because of any of the following qualifying events: (1) the covered employee's hours of employment are reduced; (2) the covered employee's employment ends for any reason (other than his or her gross misconduct); (3) the covered employee dies; (4) the covered employee becomes entitled to Medicare benefits under Part A, Part B, or both (typically, this will not be a qualifying event for covered dependent children of covered employees due to the Medicare Secondary Payer rules); (5) the covered employee and his or her spouse divorce or legally separate; or (6) the covered dependent child ceases to be eligible for coverage under the Plan as a "dependent child." Note: if coverage for a spouse or dependent child is dropped in anticipation of a qualifying event (as determined at the sole discretion of the Plan Administrator), the spouse or dependent child whose coverage was dropped (e.g. during annual enrollment) may still qualify for COBRA coverage beginning with the qualifying event provided that the notice requirements described below are satisfied.

You may also have a right to elect COBRA coverage if you are covered under the Plan as a retired employee, a covered spouse of a retired employee, or a covered dependent child of a retired employee, and lose retiree coverage as a result of the employer's commencement of proceedings under Title 11 (bankruptcy), United States Code.

NOTICE OF QUALIFYING EVENTS

PALM BEACH CTY BOARD OF CTY COMM is obligated to notify the Plan Administrator of the occurrence of these qualifying events: (1) the reduction in hours of an employee's employment; (2) the termination of the employee's employment (for reasons other than his or her gross misconduct); (3) the death of the employee; (4) the commencement of proceedings under Title 11 (bankruptcy), United States Code with respect to the employer (in the case of retiree coverage only); or (5) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For the other qualifying events (i.e., divorce or legal separation of the employee and a covered dependent child losing eligibility for coverage under the Plan as a "dependent child"), a COBRA election will be available to you *only if you notify the Plan Administrator* in accordance with the Plan's notice procedures within 60 days of the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. If you fail to provide a timely qualifying event notice in accordance with the Plan's notice procedures, the qualified beneficiaries will lose their right to a COBRA election.

ELECTING COBRA COVERAGE

When the Plan Administrator (or its designated COBRA administrator) is notified that one of these events has happened, notice of your right to elect COBRA will be provided.

Each qualified beneficiary has an independent right to make a COBRA election. That means that a covered employee may elect COBRA coverage on behalf of his or her covered spouse, and parents or legal guardians may elect COBRA coverage on behalf of their children. However, a covered employee may not waive COBRA coverage for a covered spouse or an adult covered dependent child (if the spouse or adult covered dependent child is a qualified beneficiary).

Under the law, you will have 60 days from the later of the date you would lose coverage under the Plan or the date the COBRA Election Notice is provided. If you do not elect COBRA coverage, your group health coverage will terminate in accordance with the terms of the Plan and you will lose your right to COBRA coverage.

DURATION OF COBRA COVERAGE

Unless specifically stated otherwise in the applicable SPD, COBRA coverage is measured from the date of the qualifying event, even if coverage is not immediately lost.

In the case of a loss of coverage due to the covered employee's termination of employment or reduction in hours of the covered employee's employment, COBRA coverage may generally last for up to 18 months. In the case of all other qualifying events, COBRA coverage may last for up to 36 months. If the covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both) less than 18 months before a qualifying event that is a termination or reduction in hours of employment, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which her employment terminates, COBRA coverage for her spouse and children who lost coverage as a result of her termination of employment can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

COBRA coverage under a Health Flexible Spending Account ("Health FSA") may only last through the end of the plan year in which the qualifying event occurs (unless stated otherwise in the group health plan SPD). In addition, you may not be able to elect COBRA coverage if the reimbursement available at the time of the qualifying event is less than the COBRA premium required to continue coverage through the end of the plan year.

The COBRA periods described above are maximum coverage periods. The law provides that COBRA coverage may be terminated prior to the end of the maximum coverage periods described in this notice for any of the following reasons: (1) the employer/former employer no longer provides any group health coverage to any of its employees; (2) the premium for COBRA coverage is not paid in a timely manner; (3) you first become, after electing COBRA coverage, covered under any other group health plan (as a covered employee or otherwise) which does not contain any applicable exclusion or limitation with respect to any preexisting condition (NOTE: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions are prohibited starting with plan years that begin in 2014); or (4) you first become, after electing COBRA coverage, entitled to Medicare benefits (under Part A, Part B, or both).

There are two ways in which the 18-month COBRA period of coverage resulting from a covered employee's termination of employment or reduction in hours of employment may be extended. (NOTE: The period of COBRA coverage under a Health FSA generally cannot be extended beyond the end of the plan year.)

DISABILITY EXTENSION OF COBRA COVERAGE

If a qualified beneficiary is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act and you notify the Plan Administrator (or its designated COBRA administrator, as set forth in the COBRA Coverage Election Notice) in a timely fashion, all qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours of the employee's employment may be eligible to continue coverage for an additional 11 months of COBRA coverage (for a total of 29 months). This disability must have started at some time prior to or within the first 60 days of the COBRA coverage period and must last at least until the end of

the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the Plan Administrator (or its designated COBRA administrator, as set forth in the COBRA Coverage Election Notice) of the Social Security Administration's determination of disability within 60 days after the latest of: (1) the date of the determination of disability by the Social Security Administration; (2) the date of the covered employee's termination or reduction in hours of the covered employee's employment; (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the covered employee's termination or reduction in hours of the covered employee's employment; or (4) the date that you receive this notice or the SPD. Notwithstanding the 60-day period, you must provide notice of the Social Security Administration's determination of disability prior to the end of the 18-month continuation period (irrespective of when the 60-day period would otherwise end).

The employer can charge up to 150 percent of the applicable premium during the 11-month extension in most circumstances. The disabled individual must notify the employer within 30 days of any final determination that he or she is no longer disabled. If COBRA coverage is extended to a total of 29 months, extended COBRA coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration's notice that the qualified beneficiary is no longer disabled.

SECOND QUALIFYING EVENT EXTENSION OF COBRA COVERAGE

If a qualified beneficiary who is a covered spouse or covered dependent child experiences another qualifying event during the first 18 months of COBRA coverage (because of the covered employee's termination of employment or reduction in hours of the covered employee's employment) or during an 11-month disability extension period (see "Disability Extension of COBRA Coverage," above), this qualified beneficiary receiving COBRA coverage may receive up to 18 additional months of COBRA coverage (for a total of 36 months from the original qualifying event), if notice of the second qualifying event is provided in accordance with applicable notice procedures (see "Notice Procedures for Qualified Beneficiaries," below).

This extension may be available to the covered spouse and any covered dependent children receiving COBRA coverage if the employee/former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the covered dependent child stops being eligible under the Plan as a "dependent child," *but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.*

SPECIAL RULES FOR LEAVES OF ABSENCE DUE TO SERVICES IN THE UNIFORMED SERVICES

If a covered employee takes a leave of absence to perform services in the Uniformed Services (as addressed in the Uniformed Services Employment and Reemployment Act [USERRA]) that is expected to last 31 days or more, the covered employee may be able to continue health coverage for the employee and any covered dependents until the earlier of 24 months from the date the leave began or the date that the employee fails to return to or apply for work as required under USERRA. The cost to continue this coverage for periods lasting 31 days or more is 102 percent of the applicable premium. The USERRA continuation period will run concurrent with the COBRA period described herein. Notwithstanding anything to the contrary in this notice, the rights described in this notice apply only to the COBRA continuation period. Continuation of coverage following a military leave of absence covered under USERRA will be administered in accordance with the requirements of USERRA.

CHANGE IN ADDRESS

To protect your family's rights, it is important that you keep the Plan Administrator informed if you or your family member's address changes. In such an event, please notify PALM BEACH CTY BOARD OF CTY COMM, 100 AUSTRALIAN AVE STE 200 RISK MANAGEMENT DEPT WEST PALM BEACH FL 33406. You should also keep a copy, for your records, of any notices you send to the Plan Administrator and/or CONEXIS.

NOTICE PROCEDURES FOR QUALIFIED BENEFICIARIES

Any required notice the qualified beneficiary is required to furnish (as described above) must follow these notices procedures. Notices must be sent to CONEXIS in writing (by mail or electronic transmittal [e.g., facsimile, e-mail]) to:

CONEXIS

P.O. Box 223684, Dallas, TX 75222-3684

memberservices@conexis.com

If a different address and/or procedures for providing notices to the Plan appear in the Plan's most recent SPD, you must follow those notice procedures or deliver your notice to that address.

Oral notice (including notice by telephone) is not acceptable.

Any notice you provide must contain the name of the Plan (PALM BEACH CTY BOARD OF CTY COMM group health plan); the name, CONEXIS Account Number or Social Security number, and address of the employee/former employee who is or was covered under the Plan; the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; and the certification, signature, name, address, and telephone number of the person providing the notice.

The employee/former employee who is or was covered under the Plan, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide the notices described herein. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

IF YOU HAVE QUESTIONS

Questions concerning your Plan should be addressed to PALM BEACH CTY BOARD OF CTY COMM, 100 AUSTRALIAN AVE STE 200 RISK MANAGEMENT DEPT WEST PALM BEACH FL 33406. For additional information about your COBRA rights and obligations under federal law, please review the Plan's SPD, contact the Plan Administrator identified in the SPD, or you can contact CONEXIS at 1-877-722-2667 or the above address.

In addition, you may obtain more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the EBSA website. For more information about the Marketplace, visit www.HealthCare.gov.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Risk Management/Group Insurance - Tel: 561-233-5400.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Palm Beach County Board of County Commissioners		4. Employer Identification Number (EIN) 59-6000785	
5. Employer address 301 N Olive Ave		6. Employer phone number 561-233-2030	
7. City West Palm Beach	8. State FL	9. ZIP code 33401	
10. Who can we contact about employee health coverage at this job? Risk Management/Group Insurance			
11. Phone number (if different from above) 561-233-5400		12. Email address amackey@pbcgov.org	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time employees, working at least 30 hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Lawful spouse, domestic partner

Any child of the employee who is:

- 1) less than 26 years old, or
- 2) from 26 years until the end of the calendar year in which child reaches the age of 30, provided the child is unmarried and does not have a dependent of their own, is a Florida state resident or a full-time or part-time student, and is not covered by a plan of their own or entitled to benefits under Title XVIII of the Social Security Act, or
- 3) 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under the health plan, or while covered as a dependent under a prior plan with no break in coverage.

A child born to an insured Dependent child of the employee's until such child is 18 months old.

Find the full detail of dependent eligibility in your health plan summary plan description which is posted on the Board of County Commissioner's website.

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

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

☐ **Yes** (Continue)

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

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

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

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

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

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

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

☐ Employer won't offer health coverage

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

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTICE REGARDING WELLNESS PROGRAM

The Palm Beach County Board of Commissioners Employee Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for glucose, total cholesterol, and HDL cholesterol. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of \$25 for participation in the biometric screening and \$25 for completion of the HRA via a paycheck credit. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive up to a \$50 paycheck incentive.

Additional incentives of raffles prizes may be available for employees who participate in certain health-related activities such as educational seminars, fitness classes, wellness challenges, etc. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Joanna Matwiejczuk at (561) 233-5451.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as invitations to participate in personal health coaching programs with a third-party medical insurance administrator. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Palm Beach County Board of Commissioners may

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information is a third-party biometric screening vendor and the third-party medical insurance administrator for the purposes of engagement in additional voluntary health coaching programs.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Joanna Matwiejczuk at (561) 233-5451.