WINTER SPRINGS

2023 - 2024

BENEFITS

OPEN ENROLLMENT

Enrollment Book Outline

A SUMMARY OF MY BENEFITS
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Sworn Police
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A S UMMARY OF RATES FOR ALL COVERAGES

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PLAN 14 HEALTH BENEFITS
BENEFITS OF HEALTH SAVINGS ACCOUNT
MAKING YOUR UNITED HEALTHCARE EXPERIENCE BETTER
EMPLOYEE ASSISTANCE PROGRAM
POWER POINT SLIDES TO HELP UNDERSTAND MY HEALTH BENEFITS
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PRESCRIPTION BENEFITS
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DHMO/PREPAID PLAN BENEFITS
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PURCHASING GLASSES ONLINE

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HUMANA'S LIFESTYLE DISCOUNT PROGRAM

LIFE, ADD, AND LTD

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General Employees
Sworn Police

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A SUMMARY OF VOLUNTARY OPTIONS
SHORT TERM DISABILITY BENEFITS
HOW TO CALCULATE SHORT TERM DISABILITY PREMIUM
VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

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Spouse and Child Biweekly Rates Table

ACCIDENT INSURANCE BENEFITS
CRITICAL ILLNESS INSURANCE BENEFITS
HOSPITAL INDEMNITY INSURANCE BENEFITS
MANAGING A CLAIM USING THE UNUM APPLICATION FOR MOBILE DEVICES

457 DEFERRED COMPENSATION

ICMA
NATIONWIDE

City of Winter Springs

City of Winter Springs
1126 E State Road 434
Winter Springs, FL 32708
407-327-8979
Melissa Hermes
Payroll & Benefits Coordinator
mhermes@winterspringsfl.org
www.winterspringsfl.org

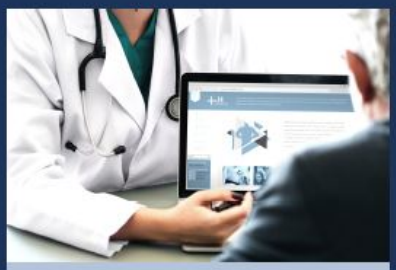
Health Insurance	**-**	**United Healthcare**	**myuhc.com 1-888-887-4114**
Call Customer Care at the number found on the back of your ID card.			**No ID Card?** If you don't have your ID card, call 1-866-414-1959. 8:00 AM - 8:00 PM in your local time zone Monday - Friday

Hometown Health (Wellness Program) – **United Healthcare** **1-844-518-8079**
Health Savings Account Any bank which will open a HEALTH SAVINGS ACCOUNT
TrustCo 851 E. State Road 434 Winter Springs, FL 32708 407-327-6064

Dental & Vision Insurance	-	**Humana**	**1-800-233-4013**
Employee Assistance Program (EAP)	-	**United Healthcare**	**1-888-887-4114**
Life Insurance	-	**Unum**	**www.unum.com/claims 1-866-679-3054**
Other Coverage	-	**Unum**	**www.unum.com/claims 1-866-679-3054**

- **Accidental Death & Dismemberment**
- **Accident**
- **Critical Illness**
- **Supplemental/Additional Life Insurance**
- **Short Term Disability**
- **Long Term Disability**

ICMARC "MissionSquare" – 401(a) City Sponsored Retirement & 457 Def Comp Employee Plan	**www.icmarc.org 1-800-669-7400**
Nationwide – 457 Deferred Compensation Employee Plan	**www.nrsforu.com 1-877-NRS-FORU**



HEALTH, VISION, DENTAL, LIFE, AD&D, STD/LTD

1st of the month following 30 days of employment.

401 & 457 RETIREMENT

The City's contributions to your retirement will begin on the 1st of the month after 6 months of employment.

VACATION / SICK

You will begin to accrue sick & vacation time beginning on your first day. Vacation time is eligible for use after 6 months of employment.

WHEN DO YOUR BENEFITS BEGIN?

CITY PAID BENEFITS

LIFE + AD&D INSURANCE

The City pays for life insurance in the amount of one year of your salary up to $50,000.

The AD&D covers unintentional death and dismemberment.

LONG TERM DISABILITY

The City's Long Term Disability (LTD) coverage will pay you 60% of your weekly salary after 6 months of being disabled.

401A + 457B MATCHING

Following 6 months of employment, the City will contribute 5% of your pay to a 401A plan for your retirement.

The City will also match an additional 2.5% if you contribute to a 457B account.

PENSION*

Sworn officers are eligible to participate in the City's Pension Plan.

You start contributing to a defined benefit pension plan following 6 months of employment.

HOW TO ENROLL IN INSURANCE COVERAGE

Full-time employees will need to fill out a benefit enrollment form and return it to Human Resources within 14 days of employment.

This form breaks down costs per plan and informs you that your election will not be able to be changed during the benefit year unless a Qualifying Event occurs.

Summary of Benefits
2023-2024

City Paid:

Basic Life and ADD- Unum - Effective 1st of the month following 30 days of employment

- Annual Salary up to $50,000

Long Term Disability- Unum - Effective 1st of the month following 30 days of employment

- 60% of pay after 6 months of disability; up to $6,000 per month

401(A)- ICMA - Effective 1st of the month following 6 months of employment

- City Contributes 5% (no mandatory employee contribution)
- City will match an employee's 457 Def Comp contribution, dollar for dollar, up to 2.5% of employee's salary
- Vesting based on date of hire. Vesting is 0% until at least 2 years
    - Completed Year 2 - 40%
    - Completed Year 3 - 60%
    - Completed Year 4 - 80%
    - Completed Year 5 - 100%

Employee Paid:

Health- United Health Care (via Florida League of Cities) - Eligible 1st of the month following 30 days of employment

- **City subsidizes employee and dependent premiums**
- $100 per month opt out (must be on another group plan)
- City HSA contribution for Plan 6:
    - Employee Only: $100/mth
    - Employee + Spouse: $200/mth
    - Employee + Family: $200/mth

Dental- Humana - Eligible 1st of the month following 30 days of employment

Vision- Humana - Eligible 1st of the month following 30 days of employment

Voluntary Life and ADD- Unum - Eligible 1st of the month following 30 days of employment

Short Term Disability- Unum - Eligible 1st of the month following 30 days of employment

- Step Rates per $10 of weekly benefit

Age	Rate	Age	Rate
15-24	$0.67	50-54	$1.06
25-29	$0.71	55-59	$1.46
30-34	$0.72	60-64	$1.72
35-39	$0.67	65-69	$1.84
40-44	$0.77	70+	$1.85
45-49	$0.92		

To calculate your Short Term premium:

Hourly Pay x Weekly Hours (40 or 42) = **Weekly Earnings**

Weekly Earnings x .6= **Weekly Benefit**

Weekly Benefit / $10.00 = **Rate Multiplier**

Rate Multiplier x Rate = **Monthly Premium**

Monthly Premium / 2 = **Bi-Weekly Premium**

457 Deferred Compensation- ICMA or Nationwide - Eligible 1st of the month following 30 days of employment

- City will match (into the 401A) what you contribute, up to 2.5% of your salary

Accident Insurance/ Critical Illness- Unum - Eligible during Open Enrollment

Summary of Benefits 2023-2024

SWORN

City Paid:

Basic Life and ADD- Unum - Effective 1st of the month following 30 days of employment

- Annual Salary up to $50,000

Long Term Disability- Unum - Effective 1st of the month following 30 days of employment

- 60% of pay after 6 months of disability; up to $6,000 per month

Pension - Effective 1st of the month following 30 days of employment

- Employee Contributes 5% in addition to City contribution
- Benefit: 3% per year of service. Vesting based on date of hire
  - Completed Year 1-6 0%
  - Completed Year 7 100%
- Unreduced Early Retirement: Age 55 with 15 years of service
- Normal Retirement: Age 65

Employee Paid:

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	Employee	Employee & Spouse	Employee & Child/ren	Employee & Family
Health				
Plan 14	$ 66.42	$ 346.73	$ 346.73	$ 377.58
Plan 6	$ 10.00	$ 212.22	$ 212.22	$ 231.79
HSA	$ 50.00	$ 100.00	$ 100.00	$ 100.00
Dental				
DMO	$ 7.41	$ 14.82	$ 16.67	$ 26.82
PPO	$ 16.10	$ 32.18	$ 45.40	$ 62.37
Vision	$ 2.45	$ 4.90	$ 4.65	$ 7.30
Dependent Life	$ 1.03	$ 1.03	$ 1.03	$ 1.03
Accident				
With Rider	$ 9.95	$ 15.21	$ 18.59	$ 23.86
Without Rider	$ 8.19	$ 11.70	$ 15.60	$ 19.11

Open enrollment

United Healthcare

Benefits designed with care

Open Enrollment

United Healthcare

Welcome to what care can do

Insurance: It's a good thing to have. It can help protect you from high costs for care and services—whether those costs are planned or unexpected. Another thing it's good for? Keeping you on track through a network of connected care. Use this guide to help you choose a plan that, at the heart of it, works every day to take good care of you.

Choosing a plan — 3 good questions to ask

1 Is your provider in the network?

A network is a group of providers and facilities who've been contracted to deliver health care services, often at a discount. Getting care from within the network may help you save money. If there's a provider you see regularly and want to keep seeing, it's a good idea to first make sure they're in the plan's network.

To find out if your preferred providers are included:

- Go to **uhc.com/providersearch > Medical Directory > Employer and Individual Plans**
- Choose the health plan you're considering and add your location to view providers in the network

2 What are your health needs?

Thinking about the care you or your family may need in the plan year ahead can help you decide the level of coverage you may need. For example, you may want a plan that offers more coverage if you:

- Have major health care needs
- See doctors or specialists often
- Are anticipating a change, like a growing family or upcoming surgery

If you see the doctor occasionally for things like an annual checkup or minor illnesses, a health plan that offers less coverage may work well for you.

3 How do you like to manage your costs?

Some people manage costs by keeping their monthly premium payments low. Others prefer paying higher monthly premiums because it tends to lower other costs, like copays or deductibles. Another good idea is to compare health plan deductible, coinsurance and out-of-pocket limit amounts. Knowing the differences can help you keep your costs in check—and know what to expect, too.

justplainclear.com

For thousands of health care terms defined simply and clearly, this is your site.

Common health care terms — good info to know

Coinsurance
The percentage of costs you pay for a covered health care service after your deductible is reached.

Copayment
Also called a copay, this is a fixed amount of money you may pay for certain covered health services, like a doctor's appointment.

Deductible
The amount you pay before your plan starts sharing costs for covered services.

Out-of-pocket limit
The most you could pay for covered services in a plan year.

Premium
A routine payment that's typically taken out of your paycheck and helps keep your plan active, so you can stay covered.

How health plans work — an example

Plan start

You pay 100%*

At the start of your plan year, you pay 100% of your covered health services until you meet your **deductible**, which is the amount you pay before your plan starts sharing costs.

Deductible reached

You pay 20%

Your plan pays 80%

Now, your health plan starts to share a percentage of the costs with you —this is your **coinsurance.***

Out-of-pocket limit met

Your plan pays 100%

Here, your plan's got you covered at 100%. Your **out-of-pocket limit** is the most you could pay for covered services in a plan year —copays and coinsurance count toward this.

Along the way, you may also be required to pay a fixed amount—or **copay**—each time you see a provider.

*Your deductible and coinsurance may vary by plan or service. This example is for illustrative purposes only. Please refer to your official plan documents for coverage details.

Quick tips, good info — it's all here

As you get ready to choose a plan for the year ahead, it's a good time to brush up on important info. Watch these short videos and you'll be well on your way to choosing the plan that best fits your needs.

Experience what care can do

Learn about our large network of providers and the programs and services included in the plans.

Watch video: Why UnitedHealthcare (1:13)

See a plan in action

Take a closer look at how copays, deductibles and more work together throughout your plan year.

Watch video: How a health plan works (1:30)

With a PCP, there's a doctor in your corner

Your primary care provider (PCP) is your health guide—someone who can help connect you to the care you need and help you avoid cost surprises. Although your health plan option may not require you and each covered family member to select a PCP,* it can be a good idea to have one.

More good reasons to have a PCP

They know your health history and health goals

They provide routine care, such as annual checkups, which may help identify potential health issues earlier

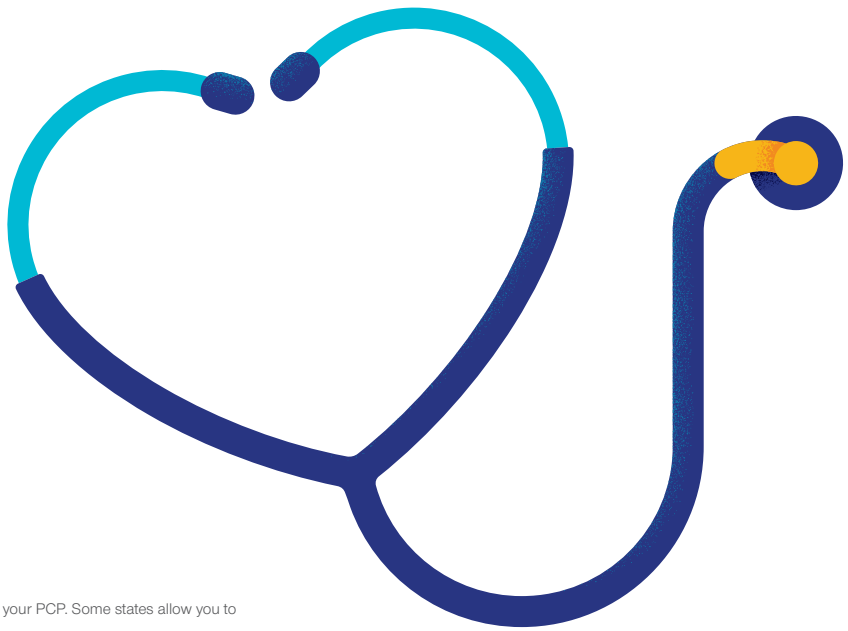
They advise you when to see a specialist and provide referrals if needed**

Look for the blue hearts

To help you find quality and cost-efficient doctors, the UnitedHealth Premium® program uses national, evidence-based, standardized measures to evaluate physicians in various specialties.

Keep up on preventive care

Preventive care—such as routine wellness exams and certain recommended screenings and immunizations—is covered by most of our plans at no additional cost when you see network providers. A preventive care visit may be a good time to help establish your relationship with your PCP and create a connection for future medical services.



*Some health plans may allow you to choose a facility rather than a doctor as your PCP. Some states allow you to choose a specialist, like an OB/GYN, as your PCP.

**Some health plans may require a referral prior to seeing another network physician or specialist.

It's so easy to connect to your plan

You'll get personalized digital tools that help you check in on your plan whenever you want—which makes it easier to stay on top of your benefit details.

myuhc.com

Your personalized member website

Built to help you manage your plan 24/7, **myuhc.com®** gives you access to all your plan info in one place, so you can:

- Find and estimate the cost of care
- See what's covered
- View claim details
- Check your plan balances
- Find network doctors

UnitedHealthcare app

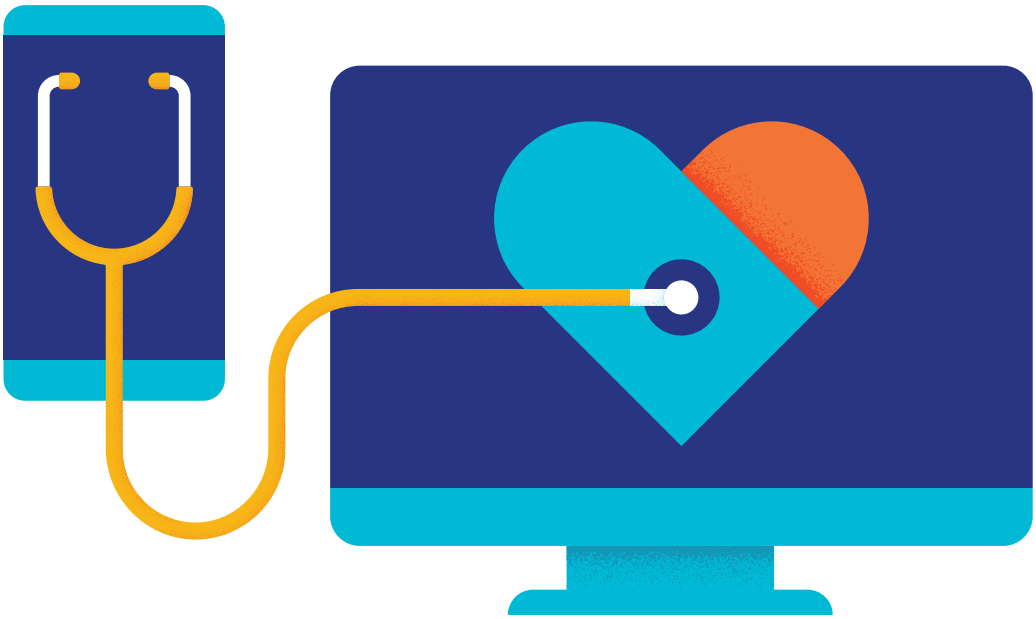
Your app for on-the-go access

When your health plan's right at your fingertips, you can manage your benefits anytime, anywhere. Download the UnitedHealthcare® app to:

- Find nearby care options in your network
- See your claim details and view progress toward your deductible
- View and share your health plan ID card
- Video chat with a doctor 24/7

Download on the App Store

GET IT ON Google Play



Here's the fine print

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Mail: UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Online: UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services:

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201

We provide free services to help you communicate with us such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

Administrative services provided by United HealthCare Services, Inc. or their affiliates.

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. **Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. You should also discuss designations with a physician before choosing him or her. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician.** Please visit myuhc.com for detailed program information and methodologies.

Members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android®. Android is a registered trademark of Google LLC. iPhone is a registered trademark of Apple, Inc.

Apple, App Store and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. Google Play and the Google Play logo are registered trademarks of Google Inc.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Take care, take note

Take care, take note

Take care, take note

22-1356861 ASO OE Brochure

2000004461 07/11/22

United Healthcare

UnitedHealthcare®

Benefit Summary
ASO Choice Plus
Florida Municipal Insurance Trust HSA Medical Plan **6**

United HealthCare Services, Inc. and Florida Municipal Insurance Trust want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – Combined Medical and Pharmacy		
Individual Deductible Family Deductible	$2,500 per year $5,000 per year	$5,000 per year $10,000 per year
• No one in the family is eligible for benefits until the family coverage deductible is met.		
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$5,000 per year $10,000 per year	$10,000 per year $20,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	80% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.		
Information of Pre-service Notification		
**Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)* ***Prior Authorization is required for Equipment in excess of $1,000.*		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 80% after Deductible has been met	* 80% after Network Deductible has been met
Dental Services – Accident Only		
	* 80% after Deductible has been met	* 80% after Network Deductible has been met
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	80% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	80% after Deductible has been met	* 80% after Network Deductible has been met

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BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Gender Dysphoria		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits. Prior Authorization is required for certain services.	
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met	* 70% after Deductible has been met
Hospice Care		
	80% after Deductible has been met	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	80% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	80% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met Partial Hospitalization/Intensive Outpatient Treatment: 80% after Deductible has been met	* 70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met Partial Hospitalization/Intensive Outpatient Treatment: 80% after Deductible has been met	* 70% after Deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	80% after Deductible has been met	70% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	80% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	80% after Deductible has been met	* 70% after Deductible has been met
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
		Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met	** 70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required.

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	80% after Deductible has been met	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible has been met	70% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met Partial Hospitalization/Intensive Outpatient Treatment: 80% after Deductible has been met	* 70% after Deductible has been met
Surgery – Outpatient		
	80% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* 80% after Deductible has been met	Non-Network Benefits are not available
	For Network Benefits, services must be received at a Designated Facility.	
Urgent Care Center Services		
	80% after Deductible has been met	70% after Deductible has been met

MEDICAL EXCLUSIONS

It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded,: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Use Disorder

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity even if there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants
Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).
Travel
Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.
Types of Care
Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing
Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
All Other Exclusions
Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia.

UnitedHealthcare®

Addendum to the Medical Benefit Summary for Self-Funded Groups

Choice Plus – Plan 6 H.S.A. Single

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	100% after Deductible has been met.	70% after Deductible has been met per visit.
Vision Exams		
Benefits are limited as follows: Routine eye exam is limited to 1 every other year.	80% after Deductible has been met.	70% after Deductible has been met per visit.

This Benefit Summary Addendum is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary Addendum conflicts in any way with the Summary Plan Description (SPF), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

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United HealthCare Services, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

UnitedHealthcare®

Benefit Summary
ASO Choice Plus
Florida Municipal Insurance Trust HSA Family Medical Plan **6**

United HealthCare Services, Inc. and Florida Municipal Insurance Trust want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – Combined Medical and Pharmacy		
Individual Deductible Family Deductible	$2,600 per year $5,000 per year	$5,000 per year $10,000 per year
• No one in the family is eligible for benefits until the family coverage deductible is met.		
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$5,000 per year $10,000 per year	$10,000 per year $20,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	80% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.		
Information of Pre-service Notification		
**Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)* ***Prior Authorization is required for Equipment in excess of $1,000.*		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 80% after Deductible has been met	* 80% after Network Deductible has been met
Dental Services – Accident Only		
	* 80% after Deductible has been met	* 80% after Network Deductible has been met
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	80% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	80% after Deductible has been met	* 80% after Network Deductible has been met

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BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Gender Dysphoria		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits. Prior Authorization is required for certain services.	
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met	* 70% after Deductible has been met
Hospice Care		
	80% after Deductible has been met	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	80% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	80% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met Partial Hospitalization/Intensive Outpatient Treatment: 80% after Deductible has been met	70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met Partial Hospitalization/Intensive Outpatient Treatment: 80% after Deductible has been met	70% after Deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	80% after Deductible has been met	70% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	80% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	80% after Deductible has been met	* 70% after Deductible has been met
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
		Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met	** 70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required.

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	80% after Deductible has been met	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible has been met	70% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met Partial Hospitalization/Intensive Outpatient Treatment: 80% after Deductible has been met	70% after Deductible has been met
Surgery – Outpatient		
	80% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* 80% after Deductible has been met	Non-Network Benefits are not available
	For Network Benefits, services must be received at a Designated Facility.	
Urgent Care Center Services		
	80% after Deductible has been met	70% after Deductible has been met

MEDICAL EXCLUSIONS

It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded,: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Use Disorder

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity even if there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated

expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia.

UnitedHealthcare®

Addendum to the Medical Benefit Summary for Self-Funded Groups

Choice Plus – Plan 6 H.S.A. Family

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	100% after Deductible has been met per visit.	70% after Deductible has been met per visit.
Vision Exams		
Benefits are limited as follows: Routine eye exam is limited to 1 every other year.	80% after Deductible has been met per visit.	70% after Deductible has been met per visit.

This Benefit Summary Addendum is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary Addendum conflicts in any way with the Summary Plan Description (SPF), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

SFTGYYYYY07

United HealthCare Services, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

UnitedHealthcare®

Benefit Summary
Outpatient Prescription Drug
Florida Municipal Insurance Trust Pharmacy Plan

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug. All Prescription Drugs on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com**® or calling Customer Care at the telephone number on the back of your ID card

A deductible and out-of-pocket maximum may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket maximum amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your copayment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the copayments outlined below. If you reach the Out-of-Pocket maximum, you will not be required to pay a copayment.

This summary of Benefits is intended only to highlight your Benefits for Prescription Drugs and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug expenses. Please refer to the Prescription Drug section of the Summary Plan Description (SPD) for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Prescription Drug section of the SPD, the Prescription Drug section of SPD shall prevail.

Annual Drug Deductible – Network and Non-Network	
Individual Deductible	See Medical Benefit Summary
Family Deductible	See Medical Benefit Summary
Out-of-Pocket Drug Maximum – Network and Non-Network	
Individual Out-of-Pocket Maximum	See Medical Benefit Summary
Family Out-of-Pocket Maximum	See Medical Benefit Summary

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	$10	$10	$25
Tier 2	$35	$35	$87.50
Tier 3	$60	$60	$150

* Only certain Prescription Drugs are available through mail order; please visit **www.myuhc.com**® or call Customer Care at the telephone number on the back of your ID card for more information.

An Ancillary Charge may apply when a covered Prescription Drug is dispensed at your [or your provider's] request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

Note: If you purchase a Prescription Drug from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug dispensed by a Network Pharmacy.

SFXRMTTT07PA

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug up to the stated supply limit. Some Prescription Drugs are subject to additional supply limits

Some Prescription Drug or Pharmaceutical Products for which Benefits are described under the Prescription Drug section of the Summary Plan Description (SPD) are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drugs require that you notify us in advance to determine whether the Prescription Drug meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Pharmacy Exclusions

Exclusions from coverage listed in the SPD apply also to this Prescription Drug section. In addition, the following exclusions apply:

Exclusions

- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drugs dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven, unless United HealthCare Services, Inc. and the Florida Municipal Insurance Trust have agreed to cover.
- Prescription Drugs furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drugs for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that Florida Municipal Insurance Trust determine do not meet the definition of a Covered Health Service.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- Prescription Drugs when prescribed to treat infertility.
- Certain Prescription Drugs for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
- Certain New Prescription Drugs and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.

- A Prescription Drug typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo provera and other injectable drugs used for contraception.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

UnitedHealthcare®

Benefit Summary
ASO Choice Plus
Florida Municipal Insurance Trust Medical Plan **14**

United HealthCare Services, Inc. and Florida Municipal Insurance Trust **want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:**

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible Family Deductible	$1,000 per year $2,000 per year	$1,000 per year $2,000 per year
• Member Copayments do not accumulate towards the Deductible		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$4,000 per year $8,000 per year	$6,000 per year $12,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	80% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover.		
Information of Prior Authorization		
**Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)* ***Prior Authorization is required for Equipment in excess of $1,000.*		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 80% after Deductible has been met	* Same as Network
Dental Services – Accident Only		
	* 80% after Deductible has been met	* Same as Network
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	80% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	100% after you pay a $200 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	* 100% after you pay a $200 Copayment per visit

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Gender Dysphoria		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits. Prior Authorization is required for certain services.	
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met.	* 70% after Deductible has been met
Hospice Care		
	80% after Deductible has been met.	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	80% after Deductible has been met.	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100% Deductible does not apply.	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a $25 Copayment per visit Partial Hospitalization/Intensive Outpatient Treatment: 100% after you pay a $25 Copayment	70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a $25 Copayment per visit Partial Hospitalization/Intensive Outpatient Treatment: 100% after you pay a $25 Copayment	70% after Deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	100% Deductible does not apply	70% Deductible does not apply
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $25 Copayment per visit	* 70% after Deductible has been met
Specialist Physician Office Visit	100% after you pay a $50 Copayment per visit	* 70% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	*Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met	** 70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required for certain services.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	100% after you pay a $25 Copayment per visit	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible has been met	70% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a $25 Copayment per visit Partial Hospitalization/Intensive Outpatient Treatment: 100% after you pay a $25 Copayment	70% after Deductible has been met
Surgery – Outpatient		
	80% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* 80% after Deductible has been met	Non-Network Benefits are not available
	For Network Benefits, services must be received at a Designated Facility.	
Urgent Care Center Services		
	100% after you pay a $35 Copayment per visit	70% after Deductible has been met

MEDICAL EXCLUSIONS

It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded,: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Use Disorder

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity even if there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan
Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.
Transplants
Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).
Travel
Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.
Types of Care
Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
Vision and Hearing
Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
All Other Exclusions
Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia.

UnitedHealthcare®

Addendum to the Medical Benefit Summary for Self-Funded Groups

Choice Plus – Plan 14

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	100%, Deductible does not apply.	70% after Deductible has been met per visit.
Vision Exams		
Benefits are limited as follows: Routine eye exam is limited to 1 every other year.	100% after you pay a $25 Copayment per visit. Deductible does not apply.	70% after Deductible has been met per visit.

This Benefit Summary Addendum is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary Addendum conflicts in any way with the Summary Plan Description (SPF), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

SFTGYYYYY07

United HealthCare Services, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

UnitedHealthcare®

Benefit Summary
Outpatient Prescription Drug
Florida Municipal Insurance Trust Pharmacy Plan

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug. All Prescription Drugs on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com**® or calling Customer Care at the telephone number on the back of your ID card

This summary of Benefits is intended only to highlight your Benefits for Prescription Drugs and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug expenses. Please refer to the Prescription Drug section of the Summary Plan Description (SPD) for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Prescription Drug section of the SPD, the Prescription Drug section of SPD shall prevail.

Annual Drug Deductible – Network and Non-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible
Out-of-Pocket Drug Maximum – Network and Non-Network	
Individual Out-of-Pocket Maximum	See Medical Benefit Summary
Family Out-of-Pocket Maximum	See Medical Benefit Summary

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	$10	$10	$25
Tier 2	$35	$35	$87.50
Tier 3	$60	$60	$150

* Only certain Prescription Drugs are available through mail order; please visit **www.myuhc.com**® or call Customer Care at the telephone number on the back of your ID card for more information.

An Ancillary Charge may apply when a covered Prescription Drug is dispensed at your [or your provider's] request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

Note: If you purchase a Prescription Drug from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug dispensed by a Network Pharmacy.

SFXRMTTT07PA

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug up to the stated supply limit. Some Prescription Drugs are subject to additional supply limits

Some Prescription Drug or Pharmaceutical Products for which Benefits are described under the Prescription Drug section of the Summary Plan Description (SPD) are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drugs require that you obtain prior authorization from us in advance to determine whether the Prescription Drug meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

You may be required to fill an initial Prescription Drug Product order and obtain on refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Pharmacy Exclusions

Exclusions from coverage listed in the SPD apply also to this Prescription Drug section. In addition, the following exclusions apply:

Exclusions

- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- .Prescription Drugs dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven, unless United HealthCare Services, Inc. and the Florida Municipal Insurance Trust have agreed to cover.
- Prescription Drugs furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drugs for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that Florida Municipal Insurance Trust determine do not meet the definition of a Covered Health Service.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- Prescription Drugs when prescribed to treat infertility.
- Certain Prescription Drugs for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
- Certain New Prescription Drugs and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.

- A Prescription Drug typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo provera and other injectable drugs used for contraception.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

Preventive care for children and adults

Scheduling regular appointments and screenings may help you manage and maintain your health

continued

United Healthcare

Focusing on regular preventive care can help you – and your family – stay healthier

Preventive care can help you avoid potentially serious health conditions and/or obtain early diagnosis and treatment. Generally, the sooner your doctor can identify and treat a medical condition, the better the outcome.

Under the Affordable Care Act (ACA),* most health plans provide coverage for certain preventive health care services at 100%, without any cost to you. Just obtain your preventive care from a health plan network provider. Diagnostic (non-preventive) services are also covered, but you may have to pay a copayment, coinsurance or deductible.

Preventive care guidelines for children**

Recommended preventive care services for children will vary based on age and may include some of the following:

- Age-appropriate well-child examination.
- Anemia screening.
- Autism and developmental screening for children under age 3.
- Behavioral counseling during well-child examination to prevent sexually transmitted infections.
- Behavioral counseling to prevent skin cancer at each well-child examination.
- Cholesterol screening for children 24 months and older.
- Fluoride application by primary care physician for children under age 6.
- Hearing screening by primary care physician.
- Newborn screenings, including metabolic screening panel, phenylketonuria (PKU), hypothyroid and sickle cell.
- Psychosocial/behavioral assessments during well-child examination.
- Assessments for tobacco, alcohol or drug use.
- Screening for obesity and counseling for children on promoting improvements in weight.
- Screening for sexually transmitted diseases, lead, depression and tuberculosis for certain children at high risk.
- Vaccines and immunizations. For more information, visit **cdc.gov/vaccines**.
- Vision screening by a primary care physician.

Not all children require all of the services identified above.*** Your doctor should give you information about your child's growth, development and general health, and answer any questions you may have.

Help protect and maintain your child's health with regular preventive care visits with a network doctor

continued

Preventive care screening guidelines and counseling services for adults**

A preventive health visit can help you see how healthy you are now and help identify any health issues before they become more serious. You and your doctor can then work together to choose the care that may be right for you. Recommended preventive care services may include the following:

- Abdominal aortic aneurysm screening for adults who are 65–75 years old and have ever smoked.
- Alcohol screening during wellness examinations, with brief counseling interventions for certain people.
- Bacteriuria screening during pregnancy.
- Blood pressure screening at each wellness examination. Certain people may also require ambulatory blood pressure measurements outside of a clinical setting. Check with your doctor.
- Breastfeeding counseling, support and supplies during pregnancy and after birth. Includes a personal-use electric breast pump.
- Breast cancer medications for risk reduction (counseling) for women at high risk of breast cancer, but low risk for adverse effects.
- Cervical cancer screening (Pap smear) for women who are 21–65 years old.
- Chlamydia and gonorrhea infection screening for sexually active women who are 24 and younger, and older women at increased risk.
- Cholesterol screening for adults who are 40–75 years old.
- Colorectal cancer screening for adults who are 45–75 years old. Ask your physician about screening methods and intervals for screening.
- Contraceptive methods that are FDA-approved for women, including education and counseling.
- Depression screening for all adults, in a primary care setting.
- Diabetes screening for adults who are 40–70 years old and overweight or obese, or for those of any age who have a history of gestational diabetes.
- Falls prevention counseling for community-dwelling older adults, during wellness examination.
- Genetic counseling and evaluation for BRCA testing and BRCA lab testing. Lab testing requires prior authorization.
- Gestational diabetes mellitus screening during pregnancy.
- Healthy diet behavioral counseling for people with cardiovascular disease risk factors, in a primary care setting.
- Healthy weight and weight gain during pregnancy behavioral counseling interventions, which adds coverage for nutrition counseling for pregnant women.
- Hepatitis B virus infection screening during pregnancy and for people at high risk.
- Hepatitis C virus infection screening for adults who are 18–79 years old.
- Human immunodeficiency virus (HIV) screening for all adults.
- Human papillomavirus DNA testing for women who are 30 and older.
- Latent tuberculosis infection screening for people at increased risk.
- Lung cancer screening with low-dose CT scan for people who are 50–80 years old with at least a 20 pack year history (with prior authorization).
- Mammography screening.
- Obesity screening and counseling at each wellness examination.
- Osteoporosis screening for women who are 65 and older and younger women at an increased risk.
- Perinatal depression counseling for pregnant or postpartum women at risk.
- Prevention of HIV and pre-exposure prophylaxis (PrEP), with antiretroviral therapy, monitoring and testing.
- Rh incapability screening during pregnancy.
- Screening for anxiety for women, during wellness examination.
- Screening for urinary incontinence for women, during wellness examination.
- Screening for intimate partner violence for women, during wellness examination.
- Sexually transmitted infections behavioral counseling for prevention for adults who are sexually active or otherwise at increased risk, in a primary care setting.
- Skin cancer behavioral counseling for prevention for young adults up to age 24 at each wellness examination.
- Syphilis screening for adults at an increased risk.
- Tobacco cessation, screening and behavioral counseling for adults who smoke, in a primary care setting (refer to pharmacy vendor for pharmacotherapy for tobacco cessation).
- Vaccines and immunizations that are FDA-approved and have explicit ACIP recommendations for routine use. For more information, visit **cdc.gov/vaccines**.
- Wellness examinations.
- Well-woman visits, including routine prenatal visits.

continued

Questions?

For more information about preventive guidelines, visit **uhc.com/preventivecare**

United Healthcare

*Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age and other health factors. UnitedHealthcare also covers other routine services that may require a copay, coinsurance or deductible. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card.

**These guidelines are based, in part, on the requirements of the Patient Protection and Affordable Care Act, and recommendations of the U.S. Preventive Services Task Force (USPSTF), the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services, and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Individuals with symptoms or at high risk for disease may need additional services or more frequent interventions that may not be covered as a preventive benefit. These guidelines do not necessarily reflect the vaccines, screenings or tests that will be covered by your benefit plan. These clinical guidelines are provided for informational purposes only, and do not constitute medical advice. Preventive care benefits may not apply to certain services listed above. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card.

***Development, psychosocial and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Discuss with your doctor how these guidelines may be right for your child, and always consult your doctor before making any decisions about medical care. These clinical guidelines are provided for informational purposes only, and do not constitute medical advice. Preventive care benefits may not apply to certain services listed above. Always refer to your plan documents for your specific coverage. Source: Centers for Disease Control and Prevention, Recommended immunization schedules for children and adolescents aged 18 years or younger - United States, 2020, at: https://www.cdc.gov/vaccines/schedules/index.html.

Additional information about the vaccines in this schedule, extent of available data, including a full list of footnotes and contraindications for vaccination is also available at cdc.gov/vaccines or from the CDC-INFO Contact Center at 1-800-CDC-INFO (1-800-232-4636) in English and Spanish, 8 a.m.–8 p.m. Eastern Time, Monday–Friday, excluding holidays.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

When life gets challenging, you've got caring, confidential help

Your Employee Assistance Program (EAP) provides support and resources to help you, and your family, with a range of issues, including:

- Managing stress, anxiety and depression
- Improving relationships at home or work
- Getting guidance on legal and financial concerns
- Coping with occupational stress and burnout support
- Addressing substance use issues

This service is provided to you at no additional cost.

$0

Call today for access to EAP resources at no additional cost

EAP provides coverage for 3 free counseling sessions per incident, per year.

Services are completely confidential and will not be shared with your employer.

Get started – call EAP 24/7 at **1-888-887-4114**

United Healthcare

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $49 or less.[3]**

Consider 24/7 Virtual Visits for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$49 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit — bringing a potential $2,000[4] cost down to $49.

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

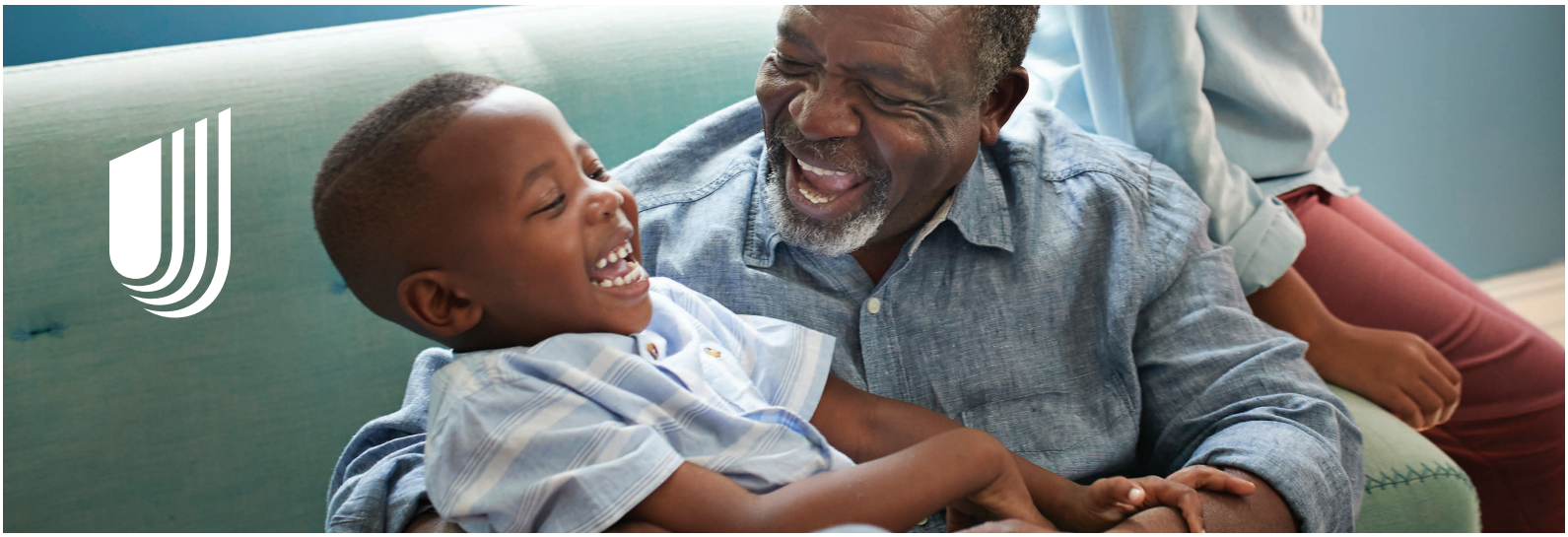
[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

[4] Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on $131 difference between average Urgent Care visit cost of $180 and Virtual Visit cost of $49; $2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.



HTH Advantage

At UnitedHealthcare, we recognize that health problems can have a tremendous impact on your life — both at work and outside of work. So we are pleased to offer you a health plan that features a special support team with our **"nurse in the family"** approach, and various health services and resources at your fingertips when you need them.

Receive support from dedicated nurses

- **Connect anytime —** You can call your nurse anytime. (If your nurse is not working, other nurses are available to help, too.)
- **1-to-1 support —** You'll have a dedicated nurse available to support you and your family.
- **Personalized service —** Your nurse can help you find a provider, schedule appointments and they can also send reminders for the entire family.
- **Specialty resources —** As needed, your nurse can connect with other resources, like doctors, pharmacists or social workers.
- **Complex care support —** If you've suffered injuries from an accident, been diagnosed with a chronic condition like diabetes or a complex condition like coronary artery disease or cancer, your nurse is there to support you and your loved ones.
- **Hospitalization support —** If you will be in the hospital in the future, you'll speak with the same nurse before and after your stay, so you know what to expect beforehand and then get the support you need during recovery.
- **Maternity support —** If you are expecting a child, you can get support from specialized nurses before, during and after pregnancy.
- **Outreach —** A nurse may call you after a hospital stay or a recent diagnosis to help connect you with information and resources you may need.

More health services and resources at your fingertips

In addition to a dedicated nurse for your family, your health plan offers lots of other resources to use whenever you need them. To find information and services available to you, visit the Health Resources tab on myuhc.com®.

Call us anytime for questions about:

- A new diagnosis
- A medical claim
- Finding a primary care physician
- Your health or medications and prescription benefits
- Managing a chronic health condition, like diabetes, coronary artery disease or asthma

Phone 1-844-518-8079, TTY **711**

United Healthcare

Building a **HEALTHY** Health Savings Account

Saving money isn't easy. But it's worth it. One of the greatest things saving can buy is peace of mind. When you have money in your health savings account (HSA), you have comfort for a healthy future. You're better prepared for expected and unexpected medical expenses.

TWO HSA SAVINGS TIPS:

1. Don't worry if you have early expenses. It isn't easy to pay out of your pocket, especially if it's a big bill. Remember that as you continue to save money in your HSA, you can take money out to reimburse yourself. Or, you might decide to not withdraw money and let it grow. It's your choice.

2. Set a savings goal. When deciding on a goal, you might want to save the amount you spent last year in health care expenses. Another possibility is to use your deductible amount as a savings goal. Even setting small goals makes a big difference in your savings.

See the back side to learn how tools on **myuhc.com**® can help you shop for the best care and build a healthy savings.

Use Your HSA Wisely

When it comes to your HSA, it's important to:

- **Open your account early**
  Be prepared for expenses early in the year
- **Set a savings goal**
  Choose an amount that works for you
- **Make regular deposits**
  Grow your account

UnitedHealthcare®

Using your HSA wisely means using the tools on **myuhc.com** that are designed to help you make better decisions about health care and lower your costs. They are available at no additional cost to you.

Choose a doctor with confidence.

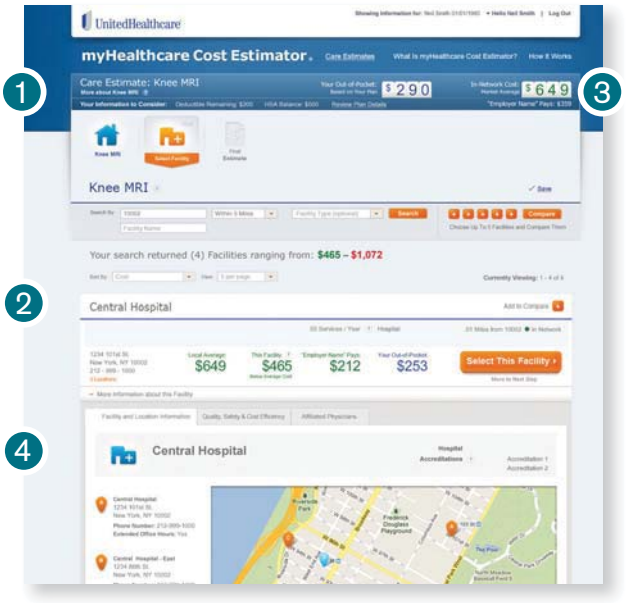
The UnitedHealth Premium® designation program takes the guesswork out of your doctor search. It recognizes physicians and hospitals for meeting quality and cost-efficiency guidelines. Just look for the stars (★★) to find them.

★ **Quality Care** + ★ **Cost-Efficient Care** = ★★ **UnitedHealth Premium Two-Star Physicians**

Know the 4Ps.

The myHealthcare Cost Estimator* makes searching for health care information an easy online shopping experience. Learn the true price of care, including lower cost options that may be available.

1. **Know your procedure.** Become educated on your procedure and learn about alternative treatment options that may be more cost-effective.
2. **Know your provider.** Where available, select a quality provider through our UnitedHealth Premium designation program, which rates doctors based on national industry quality standards and local market cost-efficiency benchmarks.
3. **Know your price.** Access personalized resources to easily estimate out-of-pocket costs for your procedure based on your specific health plan.
4. **Know the place.** Find a provider based on your geographic search criteria, view maps and print directions.



Set a course for living well and retiring well.

The Health Savings Checkup Tool gives you an easy-to-read estimate of your retirement health costs. See where you are today and how changes to your lifestyle or savings might affect your future. You'll get a personalized action plan to help you live healthier, lower future health care costs and maximize your health savings.

Think you won't spend it? Invest it.

Another benefit of building a balance in your HSA is that you may be eligible to invest a portion of your balance into mutual funds.

For more information, check with your bank.

UnitedHealthcare®

*All UnitedHealthcare members can access a cost estimator online tool. Depending on your specific benefit plan and the ZIP code that is entered, either the myHealthcare Cost Estimator or the Treatment Cost Estimator will be available. A mobile version of myHealthcare Cost Estimator is available, and additional ZIP codes and procedures will be added soon. This tool is not intended to be a guarantee of your costs or benefits. Your actual costs and/or benefits may vary. When accessing the tool, please refer to the Terms and Conditions of Use and Why Your Costs May Vary sections for further information regarding cost estimates. Refer to your health plan coverage document for information regarding your specific benefits.

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The UnitedHealthcare Health Savings Account (HSA) high deductible health plan (HDHP) is designed to comply with IRS requirements so eligible enrollees may open a Health Savings Account with a bank of their choice or through OptumHealth Bank, Member of FDIC. "UnitedHealthcare HSA" refers generally to the UnitedHealthcare HSA product, which includes a HDHP, although at times "UnitedHealthcare HSA" may refer only and specifically to the UnitedHealthcare Health Savings Account, provided in conjunction with OptumHealth Bank and not to the associated HDHP.

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UHCEW621482-000

Open Enrollment Cheat Sheet

A Handy Guide to Common Health Insurance Terms

Coinsurance:

co·in·sur·ance | *noun*

Coinsurance is the percentage of medical expenses shared by you and your insurance company after you have reached your deductible.

Co-pay:

co·pay | *noun*

A copay is a fixed amount of money you must pay each time you visit the doctor or purchase medication when using certain types of health insurance plans. This amount will vary depending on where you go for care, the type of doctor you see and kind of medicine you need. Not all plans have copays.

Deductible:

de·duct·ible | *noun*

A deductible is a fixed amount of money that you must pay for medical expenses before your insurance coverage kicks in. This does not include the amount that is taken out of your paycheck each month (your premium), so the higher your deductible amount is, the lower your monthly payments usually are.

In-and-out-of-network providers:

in· and· out· of· net·work pro·vid·ers | *noun*

Most health insurance carriers have agreements with specific health care providers or groups of health care providers to offer services to their members at a set rate. Those health care providers are referred to as "in network." Some insurance plans will require you to use in-network providers to get special rates for services. If you use providers that are not part of the carrier's network, they are called "out of network" and you will usually have to pay more for their services.

Out-of-pocket maximum:

out· of· pock·et· max·i·mum | *noun*

This is just what it sounds like: the maximum amount of money you will pay throughout the plan year. After you reach the maximum, your insurance will pay 100% of the cost of care up to your plan maximum.

Premium:

pre·mi·um | *noun*

This is the amount of money you pay for insurance each month. You will pay this regardless of how much or how little you use your insurance.

Expense	Who pays?
Out-of-Pocket Maximum	**100% insurance pays after hitting maximum**
Coinsurance	**% insurance pays/ % you pay**
Deductible	**You pay when you go to the doctor, get meds, etc.**
Premium	**The amount that comes out of your paycheck**

What is a Qualifying Event?

Elections made during open enrollment are irrevocable (cannot be changed) until the next plan year unless the employee incurs a qualifying event. When an employee has a qualifying event (qualifying change in status event) they may make changes, in line with the Consistency Rule, to their plan during the plan year. Changes to a plan include adding or removing the employee or dependent from the current plan; employees are not permitted to switch between plans.

Qualified Change in Status Events are:

- Change in legal marital status- marriage, divorce, death of spouse, legal separation or annulment;

- Change in number of tax dependents- birth, adoption or placement for adoption, or death;

- Termination or commencement of employment by the employee, spouse or dependent;

- Change in work schedule- reduction of increase in hours by the employee, spouse or dependent, including a switch between full-time and part-time, strike or lockout, or commencement or return from an unpaid leave of absence;

- Change to dependent eligibility status-due to attainment of limiting age, gain or loss of student status, marriage or any similar circumstance provided in your health insurance coverage;

- Change in residence or worksite of employee, spouse or dependent- allowable change in status if the event affects the employees eligible for coverage, for example an employee moves and is no longer eligible for a HMO insurance that limits eligibility to a specific geographic region;

- Additional qualifying event changes include HIPAA special enrollment rights, legal judgment, decree or court order, entitlement to Medicare or Medicaid, COBRA continuation coverage entitlement and election, FMLA leave, a significant change in the health

What is the Consistency Rule?

In addition to having a qualifying event, you must meet the Consistency Rule which states that in order to change your pre-tax election, you, your spouse, or your dependents must have a gain or loss of ***eligibility*** to participate in the medical or dental insurance plan(s). The increase or decrease in your pre-tax election must be consistent with the gain or loss of eligibility to participate. If the change in status event does not affect the eligibility of the insurance benefit(s), you cannot make the change.

Elections made during open enrollment are irrevocable, until the following plan year, unless the employee meets both the Qualifying Event and the Consistency Rule stipulations.

CITY OF WINTER SPRINGS

Medical Comparison 2022-2023

	FMIT- United Healthcare Plan 6 High Deductible with City HSA contribution	FMIT- United Healthcare Plan 14 PPO - Choice Plus
In Network Benefits		
Deductible (Individual / Family)	$2,500 / $5,000	$1,000 / $2,000
Coinsurance	80% / 20%	90%/10%
Out of Pocket Max (Individual / Family)	$5,000 / $10,000	$4,000/$8,000
Copays Apply to Out of Pocket Max	No	Yes
Lifetime Max	Unlimited	Unlimited
Employee Assistance Program	Included	Included
Office Visits		
Primary Office Visit	After deductible met, then 20%	$25 Copay per Visit
Special Office Visit	After deductible met, then 20%	$50 Copay per Visit
Diagnostics		
MRI, Cat Scan, PET Scan, Nuc. Med	After deductible met, then 20%	After deductible met, then 20%
Hospital & Outpatient Facility		
Inpatient Hospitalization	After deductible met, then 20%	After deductible met, then 20%
Outpatient Surgical Care	After deductible met, then 20%	After deductible met, then 20%
Emergency Room	After deductible met, then 20%	$200 Copay/No deductible
Urgent Care	After deductible met, then 20%	$35 Copay/No deductible
Prescription Drugs**		
Formulary Generic Drugs	$10 Copay	$10 Copay
Formulary Brand-Name Drugs	$35 Copay	$35 Copay
Non-Formulary Brand-Name & Generic Dru	$60 Copay	$60 Copay
Mail Order	$25/$87.5/$150	$25/$87.5/$150
Out of Network Benefits		
Deductible (Individual / Family)	$5,000 / $10,000	No Deductible
Coinsurance	70% / 30%	See Medical
Out of Pocket Max (Individual / Family)	$10,000 / $20,000	Benefit
		Summary

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 Casey Howard

.

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	4. Employer Identification Number (EIN)
Casey Howard	59-1026361
5. Employer address	**6. Employer phone number**
1126 E State Road 434	407-327-5962

7. City	8. State	9. ZIP code
Winter Springs	FL	32708

10. Who can we contact about employee health coverage at this job?	
Casey Howard	
11. Phone number (if different from above)	**12. Email address**
	choward@winterspringsfl.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:

All full time employees

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse and children

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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

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

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

Humana Dental & Vision

City of Winter Springs

2022 - 2023 Dental and Vision benefits

Humana®

FLHLPGZEN 0822

Humana Dental members

How to find and select your primary care dentist

If you have enrolled in the DHMO, you **must select** your primary care dentist (PCD)

How to search for a PCD

- Visit **Humana.com**
- Scroll down and click on “Find a Doctor or Pharmacy”
- Select “Dental/Dentist” as your search type and click “Go”
- For the coverage type select “all dental networks” radio button and enter your zip code
- Select the network:
  - HS195 DHMO prepaid
  - PPO/Traditional Preferred network (do not need to preselect a PCD)
- Set your search criteria (name, specialty or all)
- Search for a dentist
- For DHMO members: select a dentist and locate the dentist ID number
- Select the “Show Info” radio button to verify that the provider is accepting new patients.

After you have enrolled in the DHMO, you can contact Humana directly to change your primary care dentist.

Contact customer support center at **800-979-4760**.

Hours of operation: Monday through Friday, 8 a.m. – 6 p.m., EST

Effective date of your change

Any PCD changes done prior to the 15th of the month will be effective on the first day of the next month. (i.e. a change on July 12 will be effective August 1). Any PCD changes made after the 15th of the month will become effective for the first day of the second following month. (i.e. a change on July 16 will be effective September 1).

HumanaDental Prepaid HS195 Plan with Implants

Florida

Feel good about choosing a HumanaDental plan

The HumanaDental HS Series dental plan has you covered for any circumstance. Whether you simply need routine dental care or unexpected dental treatment, you know what to expect with HumanaDental.

- No waiting periods
- No claims to file
- No annual maximums

Use your HumanaDental benefits

After you enroll in a plan and receive your ID card, you can manage your plan information on your personal home page on **Humana.com**.

- You have the freedom to select any participating general dentist as your primary care dentist. To select a dental provider from our network, simply visit **Humana.com**. Once there, you can also check your benefits, email us and get a new or temporary ID card. If you prefer, contact us at 1-800-342-5209.
- Life without claim forms! With the HumanaDental Prepaid plan you pay your dentist directly, when applicable.
- Your primary dentist will provide all of your routine dental care and you will pay any copayment or discounted charges at the time of service.

Good health starts with a healthy mouth

Make dental visits a priority

One of the first lines of defense in overall health is dental care. Regular dental cleanings can help manage problems throughout the body, such as heart disease, diabetes, and stroke. The HumanaDental Prepaid plan enables you to take better care of your teeth, and you'll pay less for your dental care doing so.

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Questions?

Check out Humana.com

Call 1-800-233-4013, Monday through Friday, 8 a.m. to 6 p.m. (TDD: 1-800-325-2025).

For exclusions and limitations, please review the Specialty Benefits Regulatory and Technical Information Guide available at **Disclosure.Humana.com**.

HumanaDental Prepaid HS195 Plan with Implants

The HumanaDental Prepaid plans focus on maintaining oral health, prevention and cost-containment. Members may see a primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. HS plans copayments for listed procedures are applicable at either a participating general dentist or a participating specialist dentist.

A primary care dentist (PCD) may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

Specialists services: Should members need a specialist, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. Visit **Humana.com** to find a participating specialist.

Summary of services

Services marked with a single asterisk (*) below also require separate payment of laboratory charges, not to exceed $200. The laboratory charges must be paid to the plan dentist in addition to any applicable copayment for the service.

Appointments		Member pays
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	no charge
D9430	Office visit (normal hours)	no charge
D9440	Office visit (after regularly scheduled hours)	$ 30.00
D9986	Missed appointment	$ 10.00
D9987	Cancelled appointment	$ 10.00
D9999	Emergency visit during regular scheduled hours, by report	$ 20.00

Diagnostic		Member pays
D0120	Periodic oral examination (limited to twice in any 12 calendar months)	no charge
D0140	Limited/comprehensive/detailed and extensive oral eval	no charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	no charge
D0150	Limited/comprehensive/detailed and extensive oral eval (limited to twice in any 12 calendar months)	no charge
D0160	Limited/comprehensive/detailed and extensive oral eval	no charge
D0170	Re-evaluation—problem focused (not post-operative visit)	no charge
D0180	Limited/comprehensive/detailed and extensive oral eval (limited to twice in any 12 calendar months)	no charge
D0210	X-ray intraoral—complete series including bitewings (once per three calendar years)	no charge
D0220	X-ray intraoral—periapical, first radiographic image	no charge
D0230	X-ray intraoral—periapical, each additional radiographic image	no charge
D0240	X-rays intraoral—occlusal radiographic image	no charge
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	no charge
D0270	X-ray bitewing—single radiographic image (limited to twice in any 12 calendar months)	no charge
D0272	X-ray bitewings—two radiographic images (limited to twice in any 12 calendar months)	no charge
D0273	X-ray bitewings—three radiographic images (limited to twice in any 12 calendar months)	no charge
D0274	Bitewings—four radiographic images (limited to twice in any 12 calendar months)	no charge
D0277	X-ray bitewings, vertical—seven to eight radiographic images (limited to twice in any 12 calendar months)	no charge
D0330	Panoramic radiographic image (once per three calendar years)	no charge
D0350	Oral/facial photography images	no charge
D0415	Collect microorganisms culture & sensitivity	no charge
D0425	Caries susceptibility tests	no charge
D0431	Oral cancer screening using a special light source	$ 50.00
D0460	Pulp vitality tests (not covered if a root canal is performed)	no charge
D0470	Diagnostic casts	no charge
D0472	Pathology report—gross examination of lesion	no charge
D0473	Pathology report—microscopic examination of lesion	no charge
D0474	Pathology report—microscopic examination of lesion and area	no charge

Preventive		Member pays
D1110	Prophylaxis—adult, routine (limited to twice in any 12 calendar months, by primary care dentist)	no charge
D1111	Additional—adult prophylaxis, with or without fluoride (maximum of two additional per year)	$ 35.00
D1120	Prophylaxis—child (limited to twice in any 12 calendar months)	no charge
D1121	Additional—child prophylaxis, with or without fluoride (maximum of two additional per year)	$ 25.00
D1206	Topical application of fluoride varnish (for child <16) (limited to twice in any 12 calendar months)	no charge
D1208	Topical application of fluoride—excluding varnish (limited to twice in any 12 calendar months)	no charge
D1310	Nutrition counseling for the control of dental disease	no charge
D1320	Tobacco counseling services for the control or prevention of oral disease	no charge
D1330	Oral hygiene instruction	no charge

D1351	Sealant—per tooth (permanent teeth only to age 16)	no charge
D1510*	Space maintainer—fixed, unilateral (through age 14)	$ 25.00
D1515*	Space maintainer—fixed, bilateral (through age 14)	$ 25.00
D1520*	Space maintainer—removable, unilateral (through age 14)	$ 35.00
D1525*	Space maintainer—removable, bilateral (through age 14)	$ 35.00
D1550	Re-cement or re-bond space maintainer	$ 15.00
D1555	Removal of fixed space maintainer	$ 15.00
D1575	Distal shoe space maintainer – fixed – unilateral (through age 14; primary teeth only)	$ 55.00

Restorative		**Member pays**
D2140	Amalgam—one surface, primary or permanent	no charge
D2150	Amalgam—two surfaces, primary or permanent	no charge
D2160	Amalgam—three surfaces, primary or permanent	no charge
D2161	Amalgam—four or more surfaces, primary or permanent	no charge
D2940	Protective restoration	no charge

Resin restorative
(inlays and onlays limited to one per tooth every five years)

		Member pays
D2330	Resin based composite—one surface, anterior	no charge
D2331	Resin based composite—two surfaces, anterior	no charge
D2332	Resin based composite—three surfaces, anterior	no charge
D2335	Resin based composite—four or more surfaces or involving incisal angle (anterior)	no charge
D2390	Resin based composite crown, anterior	$ 30.00
D2391	Resin based composite—one surface, posterior	$ 30.00
D2392	Resin based composite—two surfaces, posterior	$ 45.00
D2393	Resin based composite—three surfaces, posterior	$ 65.00
D2394	Resin based composite—four or more surfaces, posterior	$ 65.00
D2510*	Inlay—metallic, one surface	$225.00
D2520*	Inlay—metallic, two surfaces	$235.00
D2530*	Inlay—metallic, three or more surfaces	$245.00
D2542*	Onlay—metallic, two surfaces	$245.00
D2543*	Onlay—metallic, three surfaces	$260.00
D2544*	Onlay—metallic, four or more surfaces	$270.00
D2610*	Inlay—porcelain/ceramic, one surface	$245.00
D2620*	Inlay—porcelain/ceramic, two surfaces	$245.00
D2630*	Inlay—porcelain/ceramic, three or more surfaces	$245.00
D2642*	Onlay—porcelain/ceramic, two surfaces	$245.00
D2643*	Onlay—porcelain/ceramic, three surfaces	$245.00
D2644*	Onlay—porcelain/ceramic, four or more surfaces	$245.00
D2650*	Inlay—resin based composite, one surface	$245.00
D2651*	Inlay—resin based composite, two surfaces	$245.00
D2652*	Inlay—resin based composite, three or more surfaces	$245.00
D2662*	Onlay—resin based composite, two surfaces	$245.00
D2663*	Onlay—resin based composite, three surfaces	$245.00
D2664*	Onlay—resin based composite, four or more surfaces	$245.00

Crown and bridge
(limited to one per tooth every five years)

		Member pays
D2710*	Crown—resin based composite, indirect	$245.00
D2712*	Crown—3/4 resin based composite, indirect	$245.00
D2720*	Crown—resin with high noble metal	$245.00
D2721	Crown—resin with predominantly base metal	$245.00
D2722*	Crown—resin with noble metal	$245.00
D2740*	Crown - porcelain/ceramic	$245.00
D2750*	Crown—porcelain fused to high noble metal	$245.00
D2751	Crown—porcelain fused to predominantly base metal	$245.00
D2752*	Crown—porcelain fused to noble metal	$245.00
D2780*	Crown—3/4 cast high noble metal	$245.00
D2781	Crown—3/4 cast predominantly base metal	$245.00
D2782*	Crown—3/4 cast noble metal	$245.00
D2783*	Crown—3/4 porcelain/ceramic	$245.00
D2790*	Crown—full cast high noble metal	$245.00
D2791	Crown—full cast predominantly base metal	$245.00
D2792*	Crown—full cast noble metal	$245.00
D2794*	Crown—titanium	$245.00
D2799	Provisional crown	no charge
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	no charge
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	no charge
D2920	Re-cement or re-bond crown	no charge
D2929	Crown-Prefabricated porcelain/ceramic crown - primary tooth	$ 25.00
D2930	Prefabricated stainless steel crown—primary tooth	$ 25.00
D2931	Prefabricated stainless steel crown—permanent tooth	$ 25.00
D2932	Prefabricated resin crown	$ 45.00
D2933	Prefabricated stainless steel crown with resin window	$ 45.00
D2950	Core buildup, including any pins	$ 70.00
D2951	Pin retention—per tooth, in addition to restoration	$ 10.00
D2952*	Cast post and core in addition to crown	$ 50.00
D2953*	Each additional cast post—same tooth	$ 50.00
D2954	Prefabricated post and core in addition to crown	$ 30.00
D2955	Post removal (not in conjunction with endodontic therapy)	$ 10.00
D2957	Each additional prefabricated post—same tooth, base metal post	$ 30.00
D2960	Labial veneer (resin laminate)—chairside	$250.00
D2961*	Labial veneer (resin laminate)—laboratory	$300.00
D2962*	Labial veneer (porcelain laminate)—laboratory	$350.00
D2970	Temporary crown (fractured tooth)	no charge
D2971	Additional procedure—new crown existing partial denture	$ 50.00
D2980	Crown repair, necessitated by restorative material failure	no charge
D2981	Inlay repair, necessitated by restorative material failure	no charge
D2982	Onlay repair, necessitated by restorative material failure	no charge
D2983	Veneer repair, necessitated by restorative material failure	no charge
D6940	Stress breaker	$110.00
D6950	Precision attachment, separate from prosthesis	$195.00
D6980*	Fixed partial denture repair necessitated by restorative material failure	$ 45.00

Prosthodontics (fixed)
(replacement limited to every five years, adjustments once per year)

		Member pays
D6210*	Pontic—cast high noble metal	$245.00
D6211	Pontic—cast predominantly base metal	$245.00
D6212*	Pontic—cast noble metal	$245.00
D6240*	Pontic—porcelain fused to high noble metal	$245.00

D6241	Pontic—porcelain fused to predominantly base metal	$245.00
D6242*	Pontic—porcelain fused to noble metal	$245.00
D6750*	Retainer crown—porcelain fused to high noble metal	$245.00
D6751	Retainer crown—porcelain fused to predominantly base metal	$245.00
D6752*	Retainer crown—porcelain fused to noble metal	$245.00
D6790*	Retainer crown—full cast high noble metal	$245.00
D6791	Retainer crown—full cast predominantly base metal.	$245.00
D6792*	Retainer crown—full cast noble metal	$245.00
D6794*	Retainer crown—titanium	$245.00
D6930	Re-cement or re-bond fixed partial denture (per unit)	no charge

Prosthodontics

(replacement limited to every five years)		**Member pays**
D5110*	Complete denture—maxillary	$325.00
D5120*	Complete denture—mandibular	$325.00
D5130*	Immediate denture—maxillary	$350.00
D5140*	Immediate denture—mandibular	$350.00
D5211*	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)	$400.00
D5212*	Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)	$400.00
D5213*	Maxillary partial denture—cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	$425.00
D5214*	Mandibular partial denture—cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	$425.00
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$350.00
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$350.00
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$350.00
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$350.00
D5225*	Maxillary partial denture—flexible (including clasps, rests and teeth)	$425.00
D5226*	Mandibular partial denture—flexible (including clasps, rests and teeth)	$425.00
D5281*	Removable unilateral partial denture—one piece cast metal (including clasps and teeth)	$300.00
D5410	Adjust complete denture—maxillary	$ 10.00
D5411	Adjust complete denture—mandibular	$ 10.00
D5421	Adjust partial denture—maxillary	$ 10.00
D5422	Adjust partial denture—mandibular	$ 10.00
D5660*	Add clasp to existing partial denture—per tooth	$ 35.00

Endodontics

(each procedure limited to once per tooth per life)		**Member pays**
D3110	Pulp cap—direct (excluding final restoration).	$ 5.00
D3120	Pulp cap—indirect (excluding final restoration).	$ 5.00
D3220	Therapeutic pulpotomy (excluding final restoration)	$ 30.00
D3221	Pulpal debridement, primary and permanent teeth (Not to be used when root canal is done on the same day)	$ 55.00
D3230	Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)	$ 40.00
D3240	Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)	$ 40.00
D3310	Root canal therapy—anterior tooth (excluding final restoration)	$100.00
D3320	Endodontic therapy, premolar tooth (excluding final restorations)	$152.00
D3330	Endodontic therapy, molar tooth (excluding final restorations)	$210.00
D3331	Treatment of root canal obstruction—non-surgical access	$ 85.00
D3332	Incomplete endodontic therapy—inoperable or fractured tooth	$ 96.00
D3333	Internal root repair of perforation defects	$ 85.00
D3346	Retreatment of previous root canal therapy—anterior	$180.00
D3347	Retreatment of previous root canal therapy—bicuspid	$280.00
D3348	Retreatment of previous root canal therapy—molar	$325.00
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$ 70.00
D3352	Apexification/recalcification—interim medication replacement (includes any necessary radiographs)	$ 70.00
D3353	Apexification/recalcification—final visit (includes any necessary radiographs)	$ 70.00
D3410	Apicoectomy—anterior	$ 95.00
D3421	Apicoectomy—premolar (first root)	$ 95.00
D3425	Apicoectomy—molar (first root)	$ 95.00
D3426	Apicoectomy—(each additional root)	$ 60.00
D3430	Retrograde filling—per root	$ 60.00
D3450	Root amputation—per root (not covered in conjunction with procedure D3920)	$ 95.00
D3910	Surgical procedure to isolate tooth with rubber dam	$ 19.00
D3920	Hemisection not included in root canal therapy	$ 90.00
D3950	Canal preparation and fitting of preformed dowel or post	$ 15.00

Periodontics (gum treatment)		**Member pays**
D4210	Gingivectomy/gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant	$110.00
D4211	Gingivectomy/gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant	$ 83.00
D4240	Gingival flap, including root planing—four or more teeth, per quadrant	$150.00
D4241	Gingival flap, including root planing—one to three teeth, per quadrant	$113.00
D4245	Apically positioned flap	$165.00
D4249	Clinical crown lengthening—hard tissue	$150.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$300.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant.	$225.00
D4263	Bone replacement graft—retained natural tooth—first site in quadrant	$180.00
D4264	Bone replacement graft—retained natural tooth—each additional site in quadrant	$ 95.00

D4265	Biological materials which can aid soft and osseous tissue regeneration	$ 95.00
D4266	Guided tissue regeneration—resorbable barrier, per site	$215.00
D4267	Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)	$255.00
D4270	Pedicle soft tissue graft procedure	$245.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$245.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$ 75.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$100.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$380.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$245.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in graft site	$120.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$ 75.00
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	$380.00
D4320	Provisional splinting—intracoronal	$ 95.00
D4321	Provisional splinting—extracoronal	$ 85.00
D4341	Periodontal scaling and root planing—four or more teeth per quadrant (limited to a maximum of four (4) quadrants will be paid in any combination per 24 calendar months)	$ 50.00
D4342	Periodontal scaling and root planing one to three teeth per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months for procedures D4341 and D4342)	$ 38.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation—full mouth, after oral evaluation (this service will reduce the number of cleanings available under D1110 and/or D1120)	$ 50.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (once per five years)	$ 50.00
D4381	Localized delivery of chemotherapeutic agents (per tooth) (limited to once per tooth per 12 months to a maximum of three tooth sites per quadrant, and performed no less than three months following active periodontal therapy)	$ 65.00
D4910	Periodontal maintenance (covered only after active periodontal therapy)	$ 40.00
D4911	Additional periodontal maintenance procedures (beyond two per 12 months)	$ 55.00

Extractions/oral and maxillofacial surgery		**Member pays**
D7111	Extraction, coronal remnants – primary tooth	$ 5.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$ 5.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$ 30.00
D7220	Removal of impacted tooth—soft tissue	$ 50.00
D7230	Removal of impacted tooth—partially bony	$ 65.00
D7240	Removal of impacted tooth—completely bony	$ 80.00
D7241	Removal of impacted tooth—completely bony, unusual complications by report	$100.00
D7250	Surgical removal of residual tooth roots	$ 40.00
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$ 50.00
D7280	Exposure of an unerupted tooth (excluding wisdom teeth)	$100.00
D7282	Mobilization of erupted or malposed tooth to aid eruption	$ 90.00
D7283	Placement of device to facilitate eruption of impacted tooth	$ 90.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$150.00
D7286	Incisional biopsy of oral tissue-soft (all others)	$ 60.00
D7287	Exfoliative cytological sample collection	$ 50.00
D7288	Brush biopsy—transepithelial sample collection	$ 50.00
D7310	Alveoloplasty in conjunction with extractions—per quadrant	$ 40.00
D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$ 15.00
D7320	Alveoloplasty not in conjunction with extractions—per quadrant	$ 60.00
D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	$ 25.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$ 80.00
D7472	Removal of torus palatinus	$ 60.00
D7473	Removal of torus mandibularis	$ 60.00
D7485	Reduction of osseous tuberosity	$ 60.00
D7510	Incision and drainage of abscess—intraoral soft tissue	$ 35.00
D7511	Incision and drainage of abscess—intraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$ 35.00
D7520	Incision and drainage of abscess—extraoral soft tissue	$ 35.00
D7521	Incision and drainage of abscess—extraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	$ 35.00
D7910	Suture of recent small wounds up to 5 cm	$ 25.00
D7960	Frenulectomy (frenectomy or frenotomy)—separate procedure	$ 50.00
D7963	Frenuloplasty	$ 50.00
D7970	Excision hyperplastic tissue—per arch	$ 55.00
D7971	Excision of pericoronoal gingiva	$ 40.00

Repairs to prosthetics		**Member pays**
D5511*	Repair broken complete denture base, mandibular	$ 35.00
D5512*	Repair broken complete denture base, maxillary	$ 35.00
D5520*	Replace missing or broken teeth—complete denture (each tooth)	$ 35.00
D5611*	Repair resin partial denture base, mandibular	$ 35.00
D5612*	Repair resin partial denture base, maxillary	$ 35.00
D5621*	Repair cast partial framework, mandibular	$ 35.00
D5622*	Repair cast partial framework, maxillary	$ 35.00

D5630*	Repair or replace broken clasp—per tooth	$ 35.00
D5640*	Replace broken teeth—per tooth	$ 35.00
D5650*	Add tooth to existing partial denture	$ 35.00
D5670*	Replace all teeth and acrylic on cast metal framework—maxillary	$165.00
D5671*	Replace all teeth and acrylic on cast metal framework—mandibular	$165.00
D5710*	Rebase complete maxillary denture	$ 75.00
D5711*	Rebase complete mandibular denture	$ 75.00
D5720*	Rebase maxillary partial denture	$ 75.00
D5721*	Rebase mandibular partial denture	$ 75.00
D5730	Reline complete maxillary denture (chairside)	$ 65.00
D5731	Reline complete mandibular denture (chairside)	$ 65.00
D5740	Reline maxillary partial denture (chairside)	$ 65.00
D5741	Reline mandibular partial denture (chairside)	$ 65.00
D5750*	Reline complete maxillary denture (laboratory)	$ 85.00
D5751*	Reline complete mandibular denture (laboratory)	$ 85.00
D5760*	Reline maxillary partial denture (laboratory)	$ 85.00
D5761*	Reline mandibular partial denture (laboratory)	$ 85.00
D5810*	Interim complete denture (maxillary)	$230.00
D5811*	Interim complete denture (mandibular)	$230.00
D5820*	Interim partial denture (maxillary)	$160.00
D5821*	Interim partial denture (mandibular)	$170.00
D5850	Tissue conditioning, maxillary	$ 20.00
D5851	Tissue conditioning, mandibular	$ 20.00
D5862*	Precision attachment, by report	$160.00
D6214*	Pontic titanium	$245.00
D6245*	Pontic—porcelain/ceramic	$245.00
D6250*	Pontic—resin with high noble metal	$245.00
D6251	Pontic—resin with predominantly base metal	$245.00
D6252*	Pontic—resin with noble metal	$245.00
D6253*	Provisional pontic	no charge
D6545*	Retainer—cast metal, resin bonded fixed prosthesis	$150.00
D6549	Resin retainer – for resin bonded fixed prosthesis	$150.00
D6600*	Retainer inlay—porcelain/ceramic, two surfaces	$245.00
D6601*	Retainer inlay—porcelain/ceramic, three or more surfaces	$245.00
D6602*	Retainer inlay—cast high noble metal, two surfaces	$245.00
D6603*	Retainer inlay—cast high noble metal, three or more surfaces	$245.00
D6604	Retainer inlay—cast predominantly base metal, two surfaces	$245.00
D6605	Retainer inlay—cast predominantly base metal, three or more surfaces	$245.00
D6606*	Retainer inlay—cast noble metal, two surfaces	$245.00
D6607*	Retainer inlay—cast noble metal, three or more surfaces	$245.00
D6608*	Retainer onlay—porcelain/ceramic, two surfaces	$245.00
D6609*	Retainer onlay—porcelain/ceramic, three or more surfaces	$245.00
D6610*	Retainer onlay—cast high noble metal, two surfaces	$245.00
D6611*	Retainer onlay—cast high noble metal, three or more surfaces	$245.00
D6612	Retainer onlay—cast predominantly base metal, two surfaces	$245.00
D6613	Retainer onlay—cast predominantly base metal, three or more surfaces	$245.00
D6614*	Retainer onlay—cast noble metal, two surfaces.	$245.00
D6615*	Retainer onlay—cast noble metal, three or more surfaces	$245.00
D6710*	Retainer crown—indirect resin based composition	$245.00
D6720*	Retainer crown—resin with high noble metal	$245.00
D6721	Retainer crown—resin with predominantly base metal.	$245.00
D6722*	Retainer crown—resin with noble metal	$245.00
D6740*	Retainer crown—porcelain/ceramic.	$245.00
D6780*	Retainer crown—3/4 cast high noble metal	$245.00
D6781	Retainer crown—3/4 cast predominantly base metal.	$245.00
D6782*	Retainer crown—3/4 cast noble metal	$245.00
D6783*	Retainer crown—3/4 porcelain/ceramic, denture	$245.00

Adjunctive general service		**Member pays**
D9110	Palliative (emergency) treatment of dental pain—minor procedure	$ 10.00
D9120	Fixed partial denture sectioning	no charge
D9210	Local anesthesia not in conjunction with operative or surgical procedures	no charge
D9211	Regional block anesthesia	no charge
D9212	Trigeminal division block anesthesia	no charge
D9215	Local anesthesia in conjunction with operative or surgical procedures	no charge
D9222	Deep sedation/general anesthesia – first 15 minutes	$ 75.00
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$ 64.00
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$ 15.00
D9239	Intravenous moderate (conscious) sedation/ analgesia – first 15 minutes	$ 75.00
D9243	Intravenous moderate (conscious) sedation/ analgesia – each subsequent 15 minute increment	$ 64.00
D9248	Non-intravenous conscious sedation	$ 15.00
D9450	Case presentation, detailed and extensive treatment planning	no charge
D9610	Non-intravenous conscious sedation	$ 15.00
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$ 25.00
D9630	Other drugs and/or medicaments, by report	$ 15.00
D9910	Application of desensitizing medicament	$ 15.00
D9940	Occlusal guard, by report	$ 85.00
D9942	Repair and/or reline of occlusal guard	$ 40.00
D9951	Occlusal adjustment—limited	$ 30.00
D9952	Occlusal adjustment—complete	$100.00

Bleaching		**Member pays**
D9972	External bleaching in office—per arch	$125.00
D9975	External bleaching in home—per arch	$125.00

Orthodontics		**Member pays**
D8070	Comprehensive orthodontic treatment of the transitional dentition.	$ 1,850.00
	Consultation	no charge
	Evaluation	$ 35.00
	Records/treatment planning.	$ 250.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$ 1,850.00
	Consultation	no charge
	Evaluation	$ 35.00
	Records/treatment planning.	$ 250.00

D8090	Comprehensive orthodontic treatment of the adult dentition	$ 1,850.00
D8680	Orthodontic retention	$ 300.00
D8693	Re-cement or re-bond fixed retainer	no charge

Implants (available for groups 10+ enrolled)

Coverage for implants:

- Implants and implant supported prostheses covered at a 50% coinsurance
- Annual Maximum Benefit of $1,500
- Lifetime Maximum Benefit of $10,000

NOTE:

- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availabilty of services.
- Unlisted procedures may be eligible for up to a 25% discount. Members may contact their participating provider to determine if any discounts apply.
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit.
- Some covered services are typically only offered by a specialist (like many oral surgery procedures)
- Additional exclusions and limitations are listed along with full plan information in your certificate of benefits. If you do not have a certificate of benefits, please review the Specialty Benefits Regulatory and Technical Information Guide available at Disclosure.Humana.com.

Offered by CompBenefits Company.

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Humana Dental PPO 14

FLORIDA

City of Winter Springs

	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	$1,500 After you reach the annual maximum amount, you will receive 30 percent coinsurance on preventive, basic, and major services for the rest of the year (excludes orthodontia.)			
Preventive services • Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 14) • Sealants (permanent molars, through age 14) • Space maintainers (primary teeth, through age 14) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		80% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14) • Periodontics (periodontal cleanings 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)	80% after deductible		50% after deductible	
Major services • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth ever 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use) • Implants (1 every 5 years for implant placement, crowns, bridges, and dentures)	50% after deductible		50% after deductible	
Orthodontia services	Child orthodontia - Covers children through age 18. Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: $1,000 lifetime orthodontia maximum.			

Humana Dental PPO 14

Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Waiting periods

Employer-sponsored funding: 10+ enrolled employees

Enrollment type	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	No
Late applicant [1, 2]	No	12 months	12 months	12 months

[1] Late applicants not allowed with open enrollment option.
[2] Waiting periods do not apply to endodontic or periodontic services unless a late applicant.

Humana Dental PPO 14

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit Humana.com.

Feel good about choosing a HumanaDental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your HumanaDental PPO plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.

* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* HumanaDental helps you feel good about your dental health so you can smile confidently.

* American Academy of Cosmetic Dentistry

Use your HumanaDental benefits

Find a dentist

With HumanaDental's PPO plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered servcies by choosing dentists in the HumanaDental PPO Network. To find a dentist in HumanaDental's PPO Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

The other side of this page gives you a summary of HumanaDental benefits. Your plan certificate describes your HumanaDental benefits, including limitations and exclusions. You can find it on MyHumana, your personal page at **HumanaDental.com** or call 1-800-233-4013.

See your dentist

Your HumanaDental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at **Humana.com**.

Learn what your plan paid

After HumanaDental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

Humana group dental plans are offered by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc., Humana Medical Plan of Utah, CompBenefits Company, CompBenefits Dental, Inc., Humana Employers Health Plan of Georgia, Inc. or DentiCare, Inc. (d/b/a CompBenefits)

This is not a complete disclosure of plan qualifications and limitations. Your agents will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

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Policy Number: FL-70090-HC L 1/14, FL-70090-HC SB 1/14

Available on PPO and Traditional Preferred plans only.

Get access to virtual dental care 24/7 with Teledentix

When it's urgent, you can see a dentist virtually

Humana members have access to $0 teledentistry, also known as virtual dental care, with Teledentix, as part of their Humana Dental plan. Teledentistry services allow you to see a dentist within minutes from your computer, smartphone or tablet.

If you're in pain or cannot visit a dentist's office, virtual dental care may be an option rather than a visit to the emergency room.

How you can use teledentistry

Typically, when you have a teledentistry visit, you will speak with a dental provider through an online video chat or a phone call. You can get access to care from the comfort of your home for a variety of dental needs. Teledentix dentists can:

- **Write prescriptions for antibiotics or pain medications when needed** *(Please note, the cost of medications are not covered by your dental plan.)*
- **Perform a visual exam for things like mouth, tooth or jaw pain**
- **Provide instructions on caring for mouth, tooth or jaw pain**
- **Help members determine if they need urgent/emergency care or home care until they can see their dentist**
- **Help members find a dentist if they don't have one or if requested**

Tips to prepare for your Teledentix virtual dental visit

1. Register on the Teledentix app, or from your computer at **Humana.teledentix.com/c/humanaondemand.**
2. Fill out any required patient forms before your appointment.
3. Make a list of any symptoms, questions or concerns in advance, so you'll be ready to discuss them with your provider.
4. Share any prescriptions, over-the-counter medicines or supplements you're currently taking with your provider. If you have a preferred pharmacy, have the name and address handy in case your provider suggests prescription medication.

To learn more about teledentistry or your Humana Dental benefits, visit Humana.com.

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Pre-determination of your Humana Dental benefits

If you expect to pay more than $300 for dental care, your dentist may submit a proposed dental treatment plan that Humana will use to determine if your dental benefits cover the treatment.

- This is known as a “predetermination of benefits” (also called “prior authorization”)
- The dental treatment plan may include:
  - A list of services to be performed, including any supporting documentation
  - A written description from the dentist of the treatment
  - An itemized list of costs

Please note: With limited exceptions, predetermination of benefits must be granted before the service is provided. It will remain valid for up to 90 days after the review and is not a guarantee of what we will pay toward the treatment.

Vision health impacts overall health

Eye health exams are an important part of routine preventive healthcare. Because many eye and vision conditions have no obvious symptoms, you may be unaware of problems. Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss.[1]

Vision care is essential to maintaining a healthy lifestyle. Eye exams can detect symptoms of diseases such as diabetes, hypertension, multiple sclerosis, brain tumors, osteoporosis and rheumatoid arthritis.[1]

Contact Humana Customer Care at 877-398-2980.
Monday - Saturday, 7:30 a.m. - 11 p.m., Eastern time,
and Sunday, 11 a.m. - 8 p.m., Eastern time
or visit **Humana.com**.

[1]LIMRA International

Choosing Humana Vision is good for your health

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

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

Humana Vision plans makes good eye health easy and budget friendly

- Get an annual eye exam for $10
- Choose from more than 108,000 access points including independent optometrists, ophthalmologists and national retail eye exam locations including LensCrafters®, Pearl Vision® and Target Optical®.

How you can save with Humana Vision

Options	Retail cost	Cost with Humana Vision	Potential savings
Exam	$70	$10	$65
Frames	$225	$52	$173
Varilux comfort (premium progressives)	$250	$55	$195
Crizal easy (anti-reflective)	$125	$22	$103
Total	**$670**	**$139**	**$531** - Almost 80% off the total retail cost

Data is based on the Humana Vision 160 plan. Example is for illustration purposes only and individual results may vary.

Humana group vision plans are offered by Humana Insurance Company, Humana Dental Insurance Company, Humana Health Benefit Plan of Louisiana, Humana Insurance Company of Kentucky, Humana Insurance Company of New York, CompBenefits Insurance Company, CompBenefits Company or The Dental Concern, Inc.

LensCrafters® Pearle Vision® Target Optical®

Frequently asked questions

What are Humana Insight Vision Plans?

Humana Insight Vision Plans are network-based vision plans that emphasize high quality routine eye healthcare from independent eye care professionals. Services and materials are provided on a prepaid basis, and the plans pay network doctors directly. Humana Insight Vision Plan members can also use non-network doctors if they wish.

How does Humana Insight Vision Plan work?

Members simply select any in-network optometrist or ophthalmologist and make their appointments. At the time of the appointment, members pay only their copayments and for any extra cosmetic options selected. There are no forms to complete or claims to file.

Members can also choose an out-of-network provider. In this case, they pay their doctor at the time of the visit and submit itemized receipts to First American Administrators for reimbursement. Benefits are paid according to a reimbursement schedule. Out-of-network claim forms can be obtained from Humana Customer Care department.

Are there any limitations to my vision benefit?

Yes, there are a few. Blended and progressive lenses are not normally required for visual welfare and are generally excluded. Elective or cosmetic items such as photochromic lenses, fashion color-coated lenses and sun lenses are not normally covered but may be provided at a discount.

Do Humana Insight Vision Plans exclude anything?

Yes, some items and services are excluded, such as:

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

What do I need to access my benefits?

It's simple. Just take your Humana Vision Insight Plan ID card to your eye doctor, and he or she will file your claim for you.

Can I go online to find out more about my plan or get assistance?

Yes. You can visit **MyHumana.com** to learn about your plan, to check your benefits, to use our Provider Locator, to send us an email and more.

How can I get additional information?

Contact Humana Customer Care at 877-398-2980. Monday -Saturday, 7:30 a.m. - 11 p.m., Eastern time, and Sunday, 11 a.m. - 8 p.m., Eastern time or visit **Humana.com**.

Humana Vision 130

FLORIDA

City of Winter Springs

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$130 allowance 20% off balance over $130	$65 allowance
Standard plastic lenses[4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	$130 allowance, 15% off balance over $130	$104 allowance
• Disposable	$130 allowance	$104 allowance
• Medically necessary	$0	$200 allowance

Humana®

Humana Vision 130

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

Optional benefits

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.

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

[3] Discounts may be available on all frames except when prohibited by the manufacturer.

[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

[5] Plan covers contact lenses or frames, but not both.

Additional plan discounts

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

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Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

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

Vision health impacts overall health

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

[1] Thompson Media Inc.

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

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

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana®

Policy number: FL-70148-01LG9/15et.al.;FL-70148-01SG9/15et.al.

A fresh look at glasses

Humana members, meet Glasses.com®

Get new glasses from the comfort of your own home. With your Humana Vision plan, you can search thousands of options on Glasses.com and have them shipped right to you. That's human care.

Here's how it works:

- Search for a pair you love from thousands of name-brand frames
- Snap and send a picture of your prescription—or have Glasses.com call the provider for it
- Select lenses suited for many types of prescriptions (including progressives and multifocals)
- Get your glasses shipped the following day—with free shipping

We'll send you frames you like with lenses in your prescription

Test your frames up to 15 days

Keep them or send them back — all with free shipping

Buy new glasses from the comfort of home: **Download the app** or visit Glasses.com today

Humana®

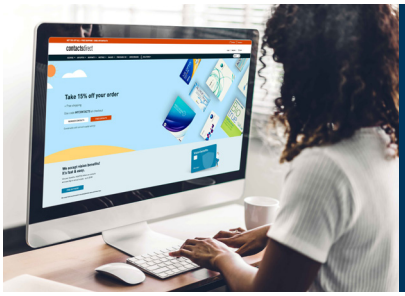
See a brighter future with contacts delivered straight to your door

Humana members, meet ContactsDirect®

We know life gets busy. You don't always have time to visit your eye doctor to pick up new contact lenses. With ContactsDirect, you don't have to. ContactsDirect is an in-network service that delivers contact lenses straight to your door. That's human care.

As a Humana member, you can apply your vision benefits directly to the contacts you buy through ContactsDirect. Choose from dozens of the name brands you know and love and have them shipped to you for free.

ContactsDirect.com is just another way Humana is helping you see a brighter future.



Check out this new, online in-network benefit

Visit us at www.contactsdirect.com

Humana®

How to order your new contacts:

1. **Visit contactsdirect.com.**
2. **Choose from a wide selection of top selling brands.**
3. **In-network vision benefits instantly apply to your purchase price.**
4. **Contact lenses will ship as soon as the prescription is verified. Most even ship that same day.**

Vision discounts to help members see a complete picture

Humana knows that good vision health is important to overall health. That's why we're committed to making sure that members get the most value from their vision benefits.

Humana is making it easier to control out-of-pocket costs with discounts and rebates. We're looking out for our members with everything you'd expect from a vision plan, plus more. That's what we call human care.

Vision plan members can learn about and access all the discounts available to you, go to **Humana.com** and sign in. Select Vision, then select Humana vision, then select Special offers.

A vast network

Our network consists of private practitioners including ophthalmologists and optometrists, LensCrafters, Target Optical and Pearle Vision; as well as online, in-network options, such as www.lenscrafters.com, www.glasses.com, www.contactsdirect.com and www.ray-ban.com.

Special offers

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

- **Lasik** – $800 off Lasik, with the Wavelight Laser, at LasikPlus Vision Centers.
- **Target Optical** – Additional $25 off when using vision insurance at Target Optical.
- **Pearle Vision** – $25 toward your purchase of a complete pair of glasses or Rx sunglasses. Can be combined with vision benefits or select offers.
- **Sunglass Hut** – $20 off any purchase or $50 off purchase of $200 or more from Sunglass Hut.
- **Glasses.com** – Get $50 off any nonprescription pair of designer sunglasses above $200, or $20 off any other non-prescription pair of sunglasses below $200.
- **ContactsDirect.com** – Get 10% off your contact lens purchase, plus free shipping at ContactsDirect.com.
- **Special pricing, lens cleaners, Croakies retainers, child and adult cases** – Special member pricing on lens cleaners, Croakies retainers, child and adult cases.
- **Prescription glasses** – 40% off second pair of prescription glasses from participating in-network providers.*
- **Sunglasses** – 20% off non-Rx sunglasses from participating in-network providers.*
- **Frames, lenses or lens options** – 20% off after coverage has reached its maximum for frames, lenses or lens options at participating in-network providers.*

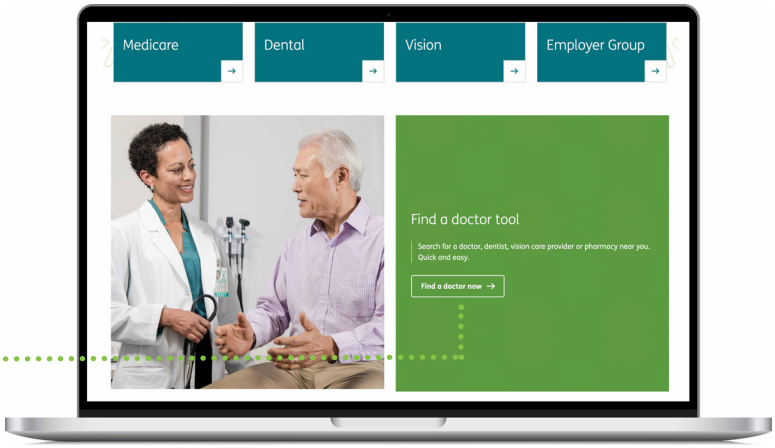
*For vision plans with qualified materials benefits only. Not applicable for exam-only vision plans.

The discounts offered through this Discount Program are not insurance or insured benefits. The program is subject to change or may be discontinued, without notice and at any time.

This is a sample of offers that are available online. Offers represented here may not be combined. To obtain offer codes, view offer terms and conditions, and search other current and available offers, visit the website listed on your ID card.

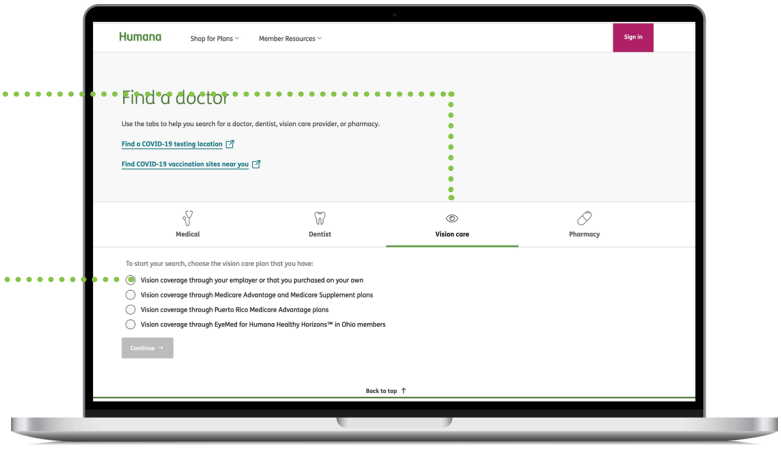
Provider directory
Humana.com

1. **Select “Find a doctor tool” on the home page**

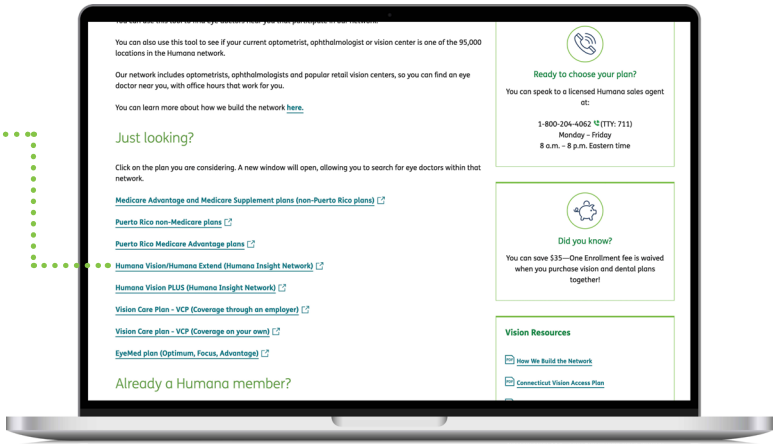


2. **Choose vision care**

3. **Select the “Vision coverage through your employer or that you purchased on your own” option and then select continue**

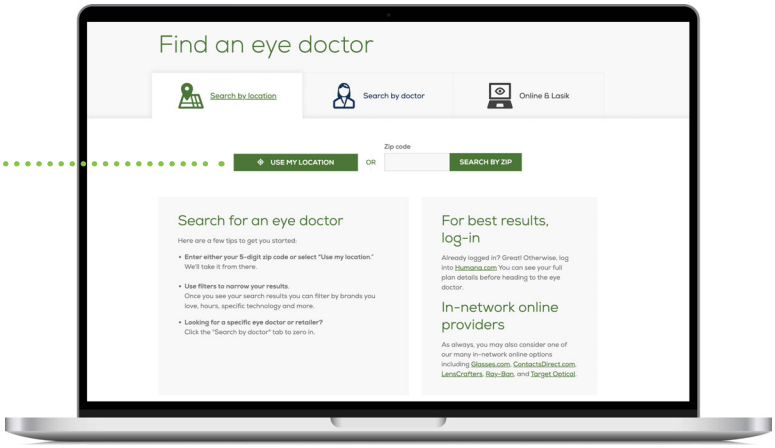


4. **Select Humana Vision/Humana Extend (Humana Insight Network) as your network plan**



5. **Select “Use my location” or “search by zip”**

6. **List of eye care providers and contact information will populate**



7. **Choose the provider that is best for you**

How to view a copy of your ID cards

What do I do if I need to visit a provider's office or pick up a prescription but I haven't received my Humana member ID card?

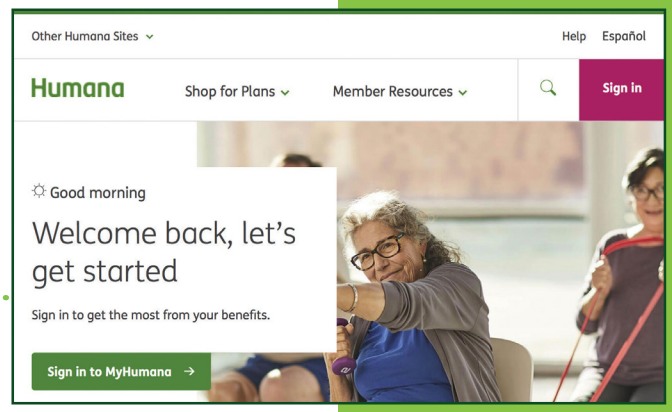
You can view, print or email your Humana member ID card at MyHumana via the website or mobile app. It's available within 10 working days of enrollment. We also mail your medical and/or dental cards to your home address.

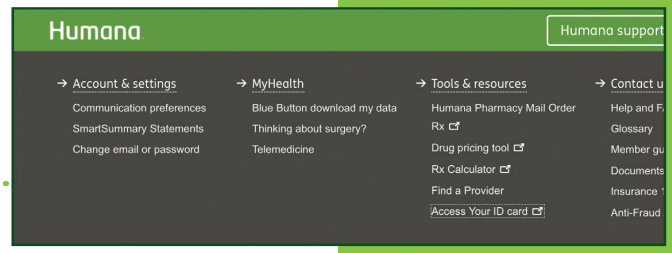
Here's how:

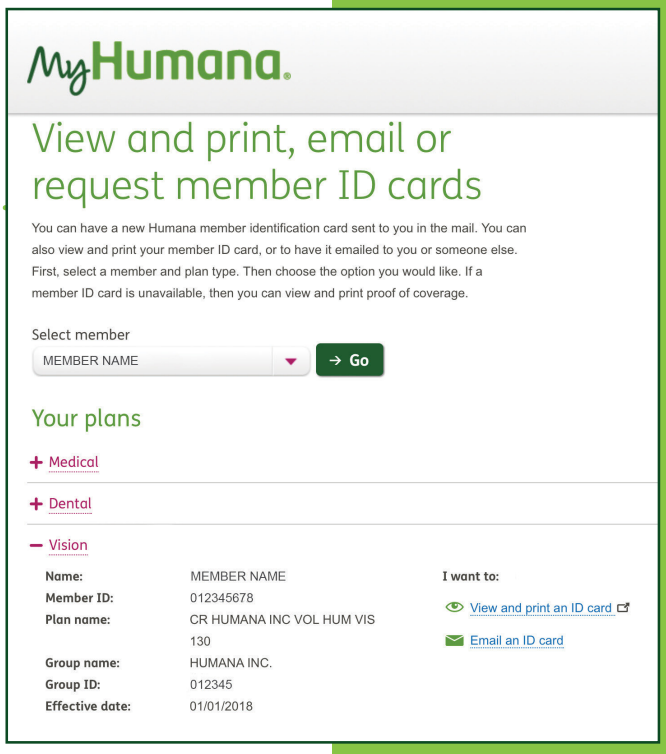
1. **Sign in or register for MyHumana on Humana.com. For registering, have your Social Security number available.**

2. **Scroll to the bottom on your MyHumana page and select "Access your ID card" under "Tools and resources."**

3. **Click on "Medical", "Dental" or "Vision" and then "View and print an ID card."**







You can also view your ID card on your smartphone with the MyHumana mobile app. It's all your plan information in one place.

For assistance or more information, call Customer Care at 1-866-4ASSIST (866-427-7478).

QUICK-START MEMBER GUIDE

WHAT ELSE COMES WITH MY PLAN?

Depending on what your company offered, here are the features of Humana's plans

DENTAL

- **Free preventive dental care** including two routine cleanings, exam and X-rays when you see an in-network dentist
- **Four additional periodontal cleanings** addresses the problem of half of American adults who suffer from gum disease*
- **No more worry about getting the on-going care you need** with our extended annual maximum benefit

VISION

- **No more than $10 for preventive eye exams**
- **Diabetic eye exam, care and testing** helps manage diabetes and helps lower overall diabetes care cost (available in most plans)
- **Get care from our network of independent eye care professionals, online and retail locations**, including LensCrafters®, Pearle Vision®, Target Optical®, glasses.com, contactsdirect, Ray-Ban

Thanks for choosing Humana. All that's left to do is register, and you'll be on your way! Visit **MyHumana.com** today to get started.

Humana®

GCHK7KAEN 0618

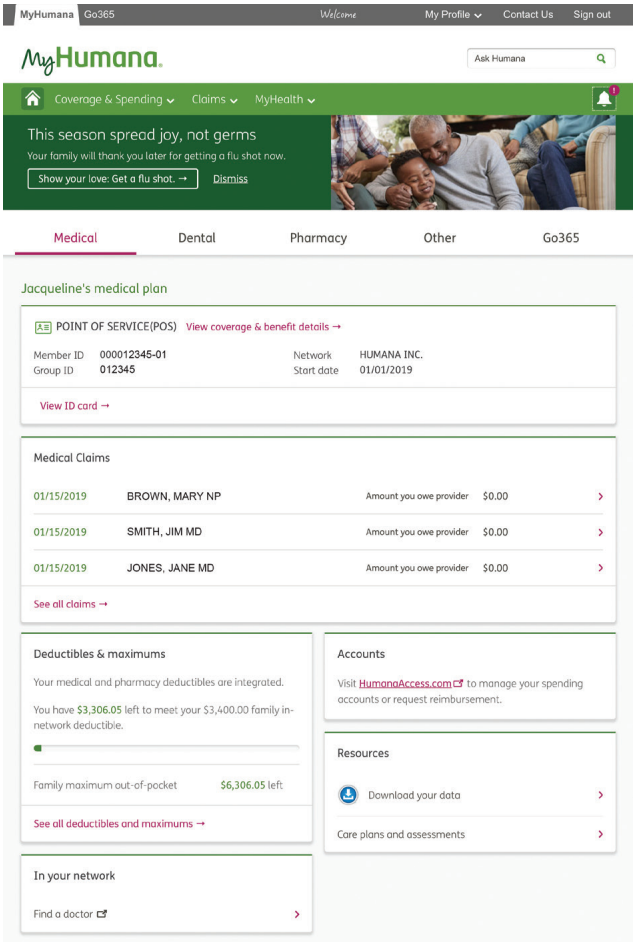
*Perio.org, https://www.perio.org/consumer/cdc-study.htm

MyHumana:

Your health plan at your fingertips

Your personal MyHumana account gives you quick, convenient and secure access to your Humana plan information, educational resources and access to wellness programs. It's available anytime, anywhere.

A dashboard that puts all your information in one spot



- Quick access to all your plans
- Chat with a representative with any of your questions about your plan
- Check the status of your claims
- View, print and email ID cards
- Review deductibles, coverage levels and limits
- Find a doctor near you
  - Search by name, specialty or condition
  - Compare doctors and get direction
- Connect with Go365® and other health and wellness resources*

Use MyHumana anywhere

Download the MyHumana Mobile app from your app store. You can also sign up for text message alerts** at **Humana.com.**

Register for MyHumana today to stay connected to your health benefits anytime you need them.

ANDROID APP ON Google play

Download on the App Store

*Check with your benefits administrator for program availability.
**Message and data rates may apply.

Important!

At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

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

Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Humana®

Humana.com

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

Notice: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Policy number: FL-70148-01LG9/15et.al.;FL-70148-01SG9/15et.al.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

Insured or administered by Humana Insurance Company or offered by CompBenefits Company.

FLHLPGZEN 0822

City of Winter Springs

Accident Insurance

How does it work?

Accident Insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.

What's included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

How much does it cost?

Your monthly premium	Option 1
You	$12.53
You and your spouse	$22.15
You and your children	$25.19
Family	$34.81

SCHEDULE OF BENEFITS

Accidental Death and Dismemberment

AD&D	
Employee	$50,000
Spouse	$25,000
Children	$12,500
Common Carrier Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	$50,000
Spouse	$25,000
Children	$12,500
Dismemberment	
Both Feet	$50,000
Both Hands	$50,000
One Foot	$25,000
One Hand	$25,000
Thumb and Index Finger of the same Hand	$12,500
Coma	
Coma	$10,000
Loss of Use	
Hearing	$25,000
Sight of one Eye	$25,000
Sight of both Eyes	$50,000
Speech	$25,000
Paralysis	
Uniplegia	$12,500
Hemi/Paraplegia	$25,000
Triplegia	$37,500
Quadriplegia	$50,000

Hospitalization

Admission	$1,000
Admission – Hospital ICU	$1,000
Daily Stay (amount)	$300
Daily Stay – Hospital ICU (amount)	$300
Short Stay	N/A
Domestic Steerage	N/A

Injury

Organized Sports	N/A
Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	$500
2nd Degree Burns - 20% or greater of skin surface	$1,000
3rd Degree Burns - Less than 5% of skin surface	$2,000
3rd Degree Burns - At least 5%, but less than 20% of skin surface	$5,000
3rd Degree Burns - 20% or greater of skin surface	$10,000
Concussion	
Concussion	$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	$150
Dislocations	
Knee joint (other than patella)	$1,650
Ankle bone or bones of the foot (other than toes)	$1,650
Hip joint	$3,375
Collarbone (sternoclavicular)	$825
Elbow joint	$500
Hand (other than Fingers)	$500
Lower Jaw	$500
Shoulder	$500
Wrist joint	$500
Collarbone (acromioclavicular and separation)	$325
Finger or Toe (Digit)	$150
Kneecap (patella)	$500
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	$200
Fractures	
Skull (except bones of Face or Nose), Depressed	$4,500
Hip or Thigh (femur)	$3,375
Skull (except bones of Face or Nose), Non-depressed	$2,250
Vertebrae, body of (other than Vertebral Processes)	$1,350
Leg (mid to upper tibia or fibula)	$1,350
Pelvis	$1,350
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	$675
Upper Arm between Elbow and Shoulder (humerus)	$675
Upper Jaw, Maxilla (other than alveolar process)	$675

Injury

Ankle (lower tibia or fibula)	$450
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	$450
Foot or Heel (other than Toes)	$450
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	$450
Kneecap (patella)	$450
Lower Jaw, Mandible (other than alveolar process)	$450
Vertebral Processes	$450
Rib	$450
Tailbone (coccyx), Sacrum	$450
Finger or Toe (Digit)	$225
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	$200
Lacerations	
No Repair	$50
Repair Less than 2 inches	$150
Repair At least 2 inches but less than 6 inches	$300
Repair 6 inches or greater	$600
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	$750
One Digit (a Thumb or Big Toe)	$1,125
Two or more Digits	$1,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	$150
Ruptured or Herniated Disc	
One Disc	$150
Two or more Discs	$250

Recovery

At-Home Care	$100
Physician Follow-Up Visits	$50
Physician Follow-Up Maximum Visits	2
Prescription Drug	$25
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	$100
Behavior Health Therapy	N/A

SCHEDULE OF BENEFITS

Recovery

Behavior Health Therapy visits	N/A
Therapy Services (chiro, speech, PT, occ)	$20
Therapy Services Maximum Days	15

Surgery

Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	$100
General Anesthesia	$250
Connective Tissue	
Exploratory without Repair	$100
Repair for One Connective Tissue	$800
Repair for Two or more Connective Tissues	$1,200
Eye Surgery	
Eye Surgery, Requiring Anesthesia	$300
Fractures	
Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Surgical Repair same bone maximum incurred per accident	1 Fracture
Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	$1,500
Exploratory	$150
Incidence per covered accident	1 Per Insured
Hernia Surgery	
Hernia Surgery	$150
Knee Cartilage	
Knee Cartilage (Meniscus) Exploratory without Repair	$150
Knee Cartilage (Meniscus) with Repair	$750
Outpatient Surgical Facility	
Outpatient Surgical Facility	$300
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	$125
One Disc	$675
Two or more Discs	$1,000

Treatment

Organized Sports	N/A
Ambulance	
Air	$1,000
Ground	$300
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	$50
Tier 2 (bedside commode, cold therapy system, crutches)	$100
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	$200
Emergency Dental Repair	
Dental Crown	$350
Dental Extraction	$115
Filling or Chip Repair	$90
Imaging	
Tier 1: X-rays or Ultrasound	$50
Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	$150
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	$150
Prosthetic Device	
One Device or Limb	$750
Two or more Devices or Limbs	$1,500
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	$250
Not Burns - 20% or greater of skin surface	$500
Treatment	
Emergency Room Treatment	$150
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	$50
Pain Management Injections (epidural, cortisone, steroid)	$100
Transfusions	$400
Transportation (per trip)	$100
Family Care	N/A
Pet Boarding (per day)	N/A
Treatment in a Physician's Office or Urgent Care Facility (initial)	$100

Active employment
You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/sites/default/files/2022-03/02110-medigap-guide-health-insurance.pdf.

Effective date of coverage
Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations
We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it;
- infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug,alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Termination of employee coverage
If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the:
- the date this policy is canceled by Unum or your employer;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made;
- the last day you are in active employment.

If we receive premium for coverage extending beyond the dates specified for coverage ending, such premium will be refunded, with the exclusion of any premium required to continue coverage in accordance with the Continuation of your Coverage during Absences provision;
However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your coverage During Absences provision.
We will provide coverage for a Payable Claim that occurs while you are covered under this certificate

Accident Insurance
THIS IS A LIMITED BENEFITS POLICY
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to certificate form GAC16-1 et al. and GAC16-2, GAC16-2-IL, GAC16-3-NH, GAC16-2-OH, and GAC16-2-UT. Policy Form GAP16-1 et al. in all states, GAP16-3-NH in New Hampshire or contact your Unum representative.
Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by: Unum Insurance Company, Portland, Maine

City of Winter Springs

Learn more about your annual Be Well Benefit

Your Unum plan pays a Be Well Benefit for one Be Well screening each year.

With Unum's Be Well Benefit, you and other covered family members can receive a valuable incentive for important tests and screenings. Many of these tests are routinely performed, so it's easy to take advantage of this benefit.

Your Critical Illness Be Well benefit is $50.

Your Accident Be Well benefit is $50.

Your Hospital Be Well benefit is $50.

BE WELL SCREENINGS

- Annual exams by a physician including sports physicals and well-child visits, dental and vision exams
- Cancer screenings including pap smear, colonoscopy
- Cardiovascular function screenings
- Cholesterol and diabetes screenings
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

IT'S EASY TO FILE A CLAIM

You can receive a benefit for tests that are performed after your initial coverage date.

Follow these simple steps:

File your claim online with a one-time registration on **unum.com**, by mail or over the phone. Simply call **1-800-635-5597** to learn more.

You will need to provide the following:

- First and last names of the **employee** and **claimant** (the employee might not be the claimant)
- Employee's **Social Security number** or **policy number**
- **Name** and **date** of the test
- Name of **physician** and the **facility** where the test was performed.

Each year, you can earn a valuable incentive just for taking care of your health. And so can each of your covered family members.

For more information, please contact your HR representative.

Better benefits at work.™

unum.com

EN-1911-BeWell FOR EMPLOYEES (5-21)

City of Winter Springs

Critical Illness Insurance

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical illnesses	
• Heart attack • Stroke • Major organ failure • End-stage kidney failure	• Coronary artery disease Major (50%): Coronary artery bypass graft or valve replacement Minor (10%): Balloon angioplasty or stent placement

Cancer conditions	
• Invasive cancer — all breast cancer is considered invasive	• Non-invasive cancer (25%) • Skin cancer — $500

Progressive diseases	Supplemental conditions
• Amyotrophic Lateral Sclerosis (ALS) • Dementia, including Alzheimer's disease • Multiple Sclerosis (MS) • Parkinson's disease • Functional loss	• Loss of sight, hearing or speech • Benign brain tumor • Coma • Permanent Paralysis • Occupational HIV, Hepatitis B, C or D • Infectious Diseases (25%)

Please refer to the certificate for complete definitions about these covered conditions. Coverage may vary by state. See exclusions and limitations.

Why should I buy coverage now?

- It's more affordable when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Be Well Benefit	
Every year, each family member who has Critical Illness coverage can also receive $50 for getting a covered Be Well Benefit screening test, such as:	
• Annual exams by a physician include sports physicals, well-child visits, dental and vision exams • Screenings for cancer, including pap smear, colonoscopy • Cardiovascular function screenings	• Screenings for cholesterol and diabetes • Imaging studies, including chest X-ray, mammography • Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You:	Choose $10,000, $20,000 or $30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can only get 100% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 100% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Monthly costs		
Age	Employee coverage: $10,000 Spouse coverage: $10,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$3.39	$3.39
25 - 29	$4.09	$4.09
30 - 34	$5.09	$5.09
35 - 39	$6.29	$6.29
40 - 44	$8.59	$8.59
45 - 49	$12.19	$12.19
50 - 54	$17.39	$17.39
55 - 59	$24.19	$24.19
60 - 64	$34.39	$34.39
65 - 69	$50.49	$50.49
70 - 74	$75.99	$75.99
75 - 79	$107.29	$107.29
80 - 84	$149.39	$149.39
85+	$235.89	$235.89

Monthly costs		
Age	Employee coverage: $20,000 Spouse coverage: $20,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$5.09	$5.09
25 - 29	$6.49	$6.49
30 - 34	$8.49	$8.49
35 - 39	$10.89	$10.89
40 - 44	$15.49	$15.49
45 - 49	$22.69	$22.69
50 - 54	$33.09	$33.09
55 - 59	$46.69	$46.69
60 - 64	$67.09	$67.09
65 - 69	$99.29	$99.29
70 - 74	$150.29	$150.29
75 - 79	$212.89	$212.89
80 - 84	$297.09	$297.09
85+	$470.09	$470.09

Monthly costs		
Age	Employee coverage: $30,000 Spouse coverage: $30,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$6.79	$6.79
25 - 29	$8.89	$8.89
30 - 34	$11.89	$11.89
35 - 39	$15.49	$15.49
40 - 44	$22.39	$22.39
45 - 49	$33.19	$33.19
50 - 54	$48.79	$48.79
55 - 59	$69.19	$69.19
60 - 64	$99.79	$99.79
65 - 69	$148.09	$148.09
70 - 74	$224.59	$224.59
75 - 79	$318.49	$318.49
80 - 84	$444.79	$444.79
85+	$704.29	$704.29

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/sites/default/files/2022-03/02110-medigap-guide-health-insurance.pdf.

Your paycheck deduction will include the cost of coverage and the Be Well Benefit. Actual billed amounts may vary.

Pre-existing conditions

We will not pay benefits for a claim when the Covered Loss occurs in the first 12 months following an Insured's Coverage Effective Date and the Covered Loss is caused by, contributed to by or occurs as the result of any of the following:

- a Pre-existing Condition; or
- complications arising from treatment or surgery for, or medications taken for, a Pre-existing Condition.

An Insured has a Pre-existing Condition if, within the 12 months just prior to their Coverage Effective Date, they have an injury or sickness, whether diagnosed or not, for which:

- medical treatment, consultation, care or services, or diagnostic measures were received or recommended to be received during that period;
- drugs or medications were taken, or prescribed to be taken during that period; or
- symptoms existed.

  Routine follow-up care to determine whether Breast Cancer has reoccurred will not be considered treatment for a Pre-existing Condition unless evidence of Breast Cancer is found during or as a result of the follow-up care.

  The Pre-existing Condition provision applies to any Insured's initial coverage and any increases in coverage. Coverage Effective Date refers to the date any initial coverage or increases in coverage become effective.

Pre-existing Condition requirements are not applicable to children who are newly acquired after your Coverage Effective Date.

Continuity of coverage

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date. Coverage is subject to payment of premium and all other terms of the certificate. If an employee is on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in the certificate. If you have not returned to Active Employment before any Insured's Date of Diagnosis, any benefits payable will be limited to what would have been paid by the prior carrier.

If the Employer replaces a critical illness policy with this Policy, or the employee becomes insured due to a merger, acquisition or affiliation, and the prior carrier's pre-existing condition requirement has been satisfied, the Pre-existing Condition requirement under this coverage will not apply. However, if the Unum certificate provides a higher level of coverage at the time it becomes effective, its Pre-existing Condition requirement will apply to any increase in coverage. If the prior carrier's pre-existing condition requirement has not been satisfied, periods of coverage applicable to the prior carrier's Pre-existing Condition will count towards satisfying the Pre-existing Condition requirement under this coverage.

Date of diagnosis must be after the coverage effective date.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

- committing or attempting to commit a felony; being engaged in an illegal occupation or activity; injuring oneself intentionally or attempting or committing suicide, whether sane or not; active participation in a riot, or insurrection. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense; participating in war or any act of war, whether declared or undeclared; combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations; voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the insured's physician; being intoxicated; and a Date of Diagnosis that occurs while an insured is legally incarcerated in a penal or correctional institution.

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the: date this policy is canceled by Unum or your employer; date you are no longer in an eligible group; date your eligible group is no longer covered; date of your death; last day of the period any required premium contributions are made; or last day you are in active employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage during Absences provision or if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness Insurance.

Unum will provide coverage for a payable claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GCIP16-1 or the Certificate Form GCIC16-1 or contact your Unum representative.

Underwritten by: Unum Insurance Company, Portland, Maine

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City of Winter Springs

Hospital Insurance

How does it work?

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is paid directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get affordable rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.

Be Well Benefit

Every year, each family member who has Hospital coverage can also receive $50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Hospital Insurance can pay benefits that help you with the costs of a covered hospital visit.

Who can get coverage?

You:	If you're actively at work.
Your spouse:	Can get coverage as long as you have purchased coverage for yourself.
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage.

How much does it cost?

Your monthly premium	
You	$20.93
You and your spouse	$44.33
You and your children	$28.03
Family	$51.43

Please refer to the certificate for complete definitions about these covered conditions. Coverage may vary by state. See exclusions and limitations.
This plan has a pre-existing condition limitation. See the disclosures for more information.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/sites/default/files/2022-03/02110-medigap-guide-health-insurance.pdf

Hospital		
Hospital Admission	Payable for a maximum of 1 day per year	$1,500

Exclusions and Limitations

Hospital insurance filed policy name is Group Hospital Indemnity Insurance Policy

Active employment
You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours per week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

Continuity of coverage
We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date.
Coverage is subject to payment of premium and all other terms of the certificate. If an employee is on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in the certificate.
If you have not returned to Active Employment before any Insured's covered loss, any benefits payable will be limited to what would have been paid by the prior carrier.
If the Employer replaces a Supplemental health policy with this Policy, or the employee becomes insured due to a merger, acquisition or affiliation, and the prior carrier's pre-existing condition requirement has been satisfied, the Pre-existing Condition requirement under this coverage will not apply. However, if the Unum certificate provides a higher level of coverage at the time it becomes effective, its Pre-existing Condition requirement will apply to any increase in coverage. If the prior carrier's pre-existing condition requirement has not been satisfied, periods of coverage applicable to the prior carrier's Pre-existing Condition will count towards satisfying the Pre-existing Condition requirement under this coverage.

Pre-existing Condition
We will not pay benefits for a claim when the Covered Loss occurs in the first 12 months following an Insured's Coverage Effective Date and the Covered Loss is caused by, contributed to by, or resulting from any of the following:
• a Pre-existing Condition; or
• complications arising from treatment or surgery for, or medications taken for, a Pre-existing Condition.
An Insured has a Pre-existing Condition if, within the 12 months just prior to their Coverage Effective Date, they have an Injury or Sickness, whether diagnosed or not, for which:
• medical treatment, consultation, care or services, or diagnostic measures were received or recommended to be received during that period; or
• drugs or medications were taken, or prescribed to be taken during that period; or
• symptoms existed; or
• an ordinarily prudent person would have sought medical care or consulted a Physician.
Pre-existing Condition requirements are not applicable to:
• Children who are newly acquired after your Coverage Effective Date.
The Pre-existing Condition provision applies to any Insured's initial coverage and any increases in coverage.
Coverage Effective Date refers to the date any initial coverage or increases in coverage become effective.

Exclusions and limitations
Unum will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
• Committing or attempting to commit a felony;
• Being engaged in an illegal occupation or activity;
• Injuring oneself intentionally or attempting or committing suicide, whether sane or not;
• Active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
• Participating in war or any act of war, whether declared or undeclared;
• Combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
• Being intoxicated;
• A Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
• Elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
• Treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
• Any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
• Voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician;
• Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
• Stroke, Alzheimer's disease, trauma, viral infection; or
• Other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.
Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of employee coverage
If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer.
Otherwise, your coverage under this certificate ends on the earliest of:
• the date the Policy is cancelled by us or your Employer;
• the date you are no longer in an Eligible Group;
• the date your Eligible Group is no longer covered;
• the date of your death;
• the last day of the period any required premium contributions are made; or
• the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision or if you elect to continue coverage for you under Portability of Hospital Indemnity Insurance.
We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.
THIS INSURANCE PROVIDES LIMITED BENEFITS
This coverage is a supplement to health insurance. It is not a substitute for comprehensive health insurance and does not qualify as minimum essential health coverage as defined in federal law. Some states may require individuals to have comprehensive medical coverage before purchasing hospital insurance.
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete definitions of coverage and availability, please refer to Certificate Form GHIC16-1 and policy form GHIP16-1 or contact your Unum representative.
Unum complies with all state civil union and domestic partner laws when applicable.

Underwritten by: Unum Insurance Company, Portland, Maine

Better benefits at work.

City of Winter Springs

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

Policy #298705

All Active Full-Time Employees Excluding Retirees

How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

Why is this coverage so valuable?

If you previously purchased coverage, you can increase it up to $150,000 to meet your growing needs — with no health questions or exams.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 50% of your life insurance benefit (up to $750,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 30 hours per week, you may apply for coverage for:

You	Choose from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings. If you previously purchased coverage, you can increase it up to $150,000, your guaranteed issue amount, with no health questions. If you previously declined coverage, you may have to answer some health questions.
Your Spouse	Get up to $500,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. If you previously purchased coverage for your spouse, they can increase their coverage up to $50,000, their guaranteed issue amount, with no health questions or exams, if eligible (see delayed effective date). If you previously declined spouse coverage, some health questions may be required.
Your Children	Get up to $10,000 of coverage in $2,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 19th birthday – or until their 26th birthday if they are full-time students. The maximum benefit for children live birth to 6 months is $1,000.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You	Get up to $500,000 of AD&D coverage for yourself in $5,000 increments to a maximum of 5 times your earnings.
Your Spouse	Get up to $500,000 of AD&D coverage for your spouse in $5,000 increments, if eligible (see delayed effective date).
Your Children	Get up to $10,000 of coverage for your children in $2,000 increments if eligible (see delayed effective date).

No questions or health exams required for AD&D coverage. Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Term Life Insurance and Accidental Death & Dismemberment (AD&D)

How much coverage can I get?

Calculate your costs

1. **Enter the Term Life coverage amount you want.†**
2. **Divide by the amount shown.**
3. **Multiply by the rate. Use the Term Life rate table (at right) to find the rate based on age.** (Choose the age you will be when your coverage becomes effective. To determine your spouse rate, choose the age the employee will be when coverage becomes effective. See your plan administrator for your plan effective date.)
4. **Enter your cost.**

Term Life	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $_____	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $_____	= $_____
Child	$_____,000	÷ $2,000 = $_____	X $_____	= $_____
			Total cost	

Term Life monthly rate for employee	
Age	Per $10,000 of coverage
	Cost
15-24	$0.680
25-29	$0.780
30-34	$0.970
35-39	$1.380
40-44	$1.970
45-49	$3.140
50-54	$4.990
55-59	$7.610
60-64	$11.970
65-69	$20.780
70-74	$37.080
75+	$72.660

Spouse monthly rate
Per $5,000 of coverage
Cost
$0.295
$0.335
$0.425
$0.615
$0.885
$1.380
$2.155
$3.300
$5.645
$9.645
$17.180
$34.410

Child monthly rate
$0.764 per $2,000 of coverage

1. **Enter the AD&D coverage amount you want.**
2. **Divide by the amount shown.**
3. **Multiply by the rate. Use the AD&D rate table (at right) to find the rate.**
4. **Enter your cost.**

AD&D	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $0.650	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $0.340	= $_____
Child	$_____,000	÷ $2,000 = $_____	X $0.068	= $_____
			Total cost	

AD&D monthly rates		
	Coverage amount	Rate
Employee	per $10,000 of coverage	$0.650
Spouse	per $5,000 of coverage	$0.340
Child	per $2,000 of coverage	$0.680

Billed amount may vary slightly.

If you apply for coverage above the guaranteed issue amount, you will be asked health-related questions which may affect your ability to get the larger coverage amount. In order to purchase coverage for your dependents, you must buy coverage for yourself. Coverage amounts cannot exceed 100% of your coverage amounts.

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age reduction

Coverage amounts for Life and AD&D Insurance for you and your dependents will reduce to 65% of the original amount when you reach age 65, and will reduce to 50% of the original amount when you reach age 70. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Better benefits at work.

City of Winter Springs

Short Term Disability Insurance

can pay you a weekly benefit if you have a covered disability that keeps you from working.

Policy #298706

All-Full Time Employees

How does it work?

If a covered illness or injury keeps you from working, Short Term Disability Insurance can replace part of your income while you recover. As long as you remain disabled, you can receive payments for up to 24 weeks.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

What's covered?

This insurance may cover a variety of conditions and injuries. Here are Unum's top reasons for short term disability claims:[1]

- Normal pregnancy
- Injuries
- Joint disorders
- Back disorders
- Digestive disorders

Consider your weekly expenses

Food	$_____
Transportation (gas, car payments, repairs)	_____
Child care/elder care	_____
Mortgage/rent	_____
Utilities (electric, water, cable, phone)	_____
Medical costs (co-pays, medications)	_____
Insurance (health, life, car, home)	_____
Total weekly expenses	$_____

1 Unum internal data, 2015

Short Term Disability Insurance

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of 30 hours per week. **Coverage amounts** Cover 60% of your weekly income, up to a maximum benefit of $1,000 per week. The weekly benefit may be reduced or offset by other sources of income. *See the Legal Disclosures for more information

! If you didn't get coverage when you were first eligible, you'll have to answer medical questions now. If you're newly eligible, you are guaranteed coverage now with no medical questions. If you already have coverage, you can increase it up to the maximum available with no medical questions. New coverage may be subject to pre-existing condition limitations.

Elimination period (EP)

This is the number of days that must pass between your first day of a covered disability and the day you can begin to receive your disability benefits.

Your benefits would begin after you become disabled for 7 days.

Benefit duration (BD)

The maximum number of weeks you can receive benefits while you're disabled. You have a 24 week benefit duration.

Calculate your cost

- **For step 2:**
  Enter your rate from the Rate Chart, based on your age.

  (Choose the age you will be when your coverage becomes effective. See your plan administrator for your plan effective date.)

Disability worksheet

1 Calculate your weekly disability benefit.

$_____ ÷ 52 = $_____ x 60% = $_____

Your annual earnings | Your weekly earnings | (Max % of income covered) | Max weekly benefit available (if the amount exceeds the plan max of $1,000, enter $1,000.

2 Calculate your cost per paycheck.

$_____ ÷ 10 = $_____ x $_____ = $_____ x 12 = $_____ ÷ 12 = $_____

Your weekly benefit amount | Your rate | Your monthly cost | Your annual cost | Number of paychecks per year | Your cost per paycheck

Age	Rates
15-24	$0.670
25-29	$0.710
30-34	$0.720
35-39	$0.670
40-44	$0.770
45-49	$0.920
50-54	$1.060
55-59	$1.460
60-64	$1.720
65-69	$1.840
70-99	$1.850

Billed amount may vary slightly. Your rate is based on your age and will increase as you move to the next age band. * The maximum covered annual income is $86,666.

Short Term Disability Insurance

Exclusions and limitations

Active employee

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by City of Winter Springs for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Definition of disability

You are considered disabled when Unum determines that, due to sickness or injury:

- You are unable to perform any of the material and substantial duties of your regular occupation; and
- You are not working in any occupation.

You must be under the regular care of a physician in order to be considered disabled. The loss of a professional or occupational license or certification does not, in itself, constitute disability.

"Substantial and material acts" means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified.Unless the policy specifies otherwise, as part of the disability claims evaluation process, Unum will evaluate your occupation based on how it is normally performed in the national economy, not how work is performed for a specific employer, at a specific location or in a specific region.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while you are disabled, including such items as group disability benefits or other amounts you receive or are entitled to receive:

- Workers' compensation or similar occupational benefit laws
- State compulsory benefit laws
- Automobile liability insurance policy
- Motor vehicle insurance policy or plan
- No fault motor vehicle plan
- Legal judgments and settlements
- Salary continuation or sick leave plans, if applicable
- Other group or association disability programs or insurance
- Social Security or similar governmental programs

Exclusions and limitations

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from:

- War, declared or undeclared or any act of war
- Active participation in a riot
- Intentionally self-inflicted injuries;
- Loss of professional license, occupational license or certification;
- Commission of a crime for which you have been convicted;
- Any period of disability during which you are incarcerated;
- Any occupational injury or sickness (this will not apply to a partner or sole proprietor who cannot be covered by law under workers' compensation or any similar law);

The loss of a professional or occupational license does not, in itself, constitute disability.

Termination of coverage

Your coverage under the policy ends on the earliest of the following:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim that occurs while you are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al., or contact your Unum representative.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Not in the plan? Then, what's your plan?

I have three numbers for you: **457**

What is 457?

A 457 deferred compensation plan is supplemental retirement-savings program that offers a tax-advantaged way to invest for potentially more retirement income. Pre-tax contributions and any earnings are taxed as ordinary income when withdrawn.*

Why join a 457 plan?

By investing through your employer's 457 deferred comp plan, you may be able to fill the potential retirement-income gap between what your pension provides and what you may need. Consider this: A 2010 study estimated that the *present value of lifetime uninsured health care costs* for a typical married couple age 65 is about $197,000.[1]

How do you put money in your account?

That's the easiest part! Your contributions are automatically deducted before taxes from your pay and contributed to your 457 plan account, and then invested as you direct.*

Deferred comp is designed for long-term investing. However, if you leave employment with your 457 plan sponsor, you can withdraw money without paying a 10% penalty. Consider that, if you're thinking about early retirement.

What about the risks of investing?

Investing involves market risk, including possible loss of principal. But you also face several other risks. While your Nationwide Retirement Specialist cannot offer investment, tax or legal advice, we'll help you put the various risks into perspective and explain strategies that may help you deal with them.

Retirement Specialists are registered representatives of Nationwide Investment Services Corporation, member FINRA.

**Note: If your employer's 457 plan offers and you take advantage of a Roth option, your contributions are taken after taxes are applied, but withdrawals of contributions and their potential earnings would be tax-free (subject to certain conditions).*

Sources:
[1]How Much Is Enough? The Distribution of Lifetime Health Care Costs, Anthony Webb and Natalia Zhivan, Center for Retirement Research at Boston College, Feb. 2010.

NRM-9461AO (12/12)

How do I get started in a 457 plan?

Nationwide
On Your Side

ICMA-RC is now

MissionSquare RETIREMENT

Meet your Retirement Plans Specialist

Elvin Ramirez,
Retirement Plans Specialist,
202-295-7575| eramirez@missionsq.org

Your salaried (non-commission-based) MissionSquare Retirement Plans Specialist is motivated every day to help you build a path to financial security. Your Retirement Plans Specialist is responsible for providing on-site services, including enrollment, investment education, retirement readiness education, and individual informational meetings.

To help serve you better, below is a contact guide:

Contact your Retirement Plans Specialist, if you need assistance with:

- Enrollment questions
- Roll-ins into your MissionSquare account
- Investment strategy, account management, and how much to save
- A pre-retirement checkup

Visit the Retirement Education Center at www.icmarc.org/education for tips and tools to help you save, invest, and realize retirement.

Download the MissionSquare mobile app today!

Download on the App Store | GET IT ON Google Play

Log into your account:

Access your account at **www.icmarc.org** or contact MissionSquare Participant Services at (800) 669-7400, if you need assistance with:

- Account login or website resources
- Changing or verifing your 457 plan or Roth IRA contribution amount *(Roth IRA contributions can only be changed online.)*
- Investment changes *(allocations and transfers between funds)*
- Withdrawals or distributions
- Forms and brochure requests
- Balance and quarterly statement inquiries
- Account maintenance and transactions
- Personal information updates
- All other questions

MissionSquare RETIREMENT

Get to Know Your 457 Deferred Compensation Plan

A smart addition to any pension or Social Security benefits you may receive, your **457 Deferred Compensation Plan** offers simple and flexible ways to increase your retirement savings for a more secure and confident financial future.

A Retirement Plan with Benefits

With your 457 plan, you're in control of how much you save and where you invest those savings, while enjoying tax advantages.

- Contributions are made during your employment, and you can change, stop, and restart them at any time.
- Your account's value is based on those contributions and subsequent investment returns.
- Earnings are not subject to tax until withdrawn.
- You have control over:
  - How your money in the account is invested
  - How funds are withdrawn following your separation from service
  - Who receives any remaining assets upon your death

Contribute what you can.

For 2022, you can contribute up to $20,500, or $27,000 if age 50 or over. More information about current contribution limits, including Age 50 Catch-Up and Pre-Retirement Catch-Up limits, is available at **www.icmarc.org/contributionlimits**.

MissionSquare can help you decide how much to save and how to invest through **Guided Pathways®**. Learn more: **www.icmarc.org/guidedpathways**

457 plans are unique.

Unlike other retirement accounts, you don't have to qualify for an exception to avoid the 10% IRS penalty tax on withdrawals of your contributions and associated earnings before age 59½. Just remember that your 457 plan is designed to help you meet your retirement goals. Any withdrawals prior to retirement may reduce your future retirement security.

Contributions

Pre-tax contributions you make reduce your taxable income for the year. These contributions and all associated earnings won't be taxed until you withdraw them – boosting account growth.

You also may be able to make after-tax **Roth contributions,** if offered by your employer. While they don't reduce your taxable income for the year, future withdrawals may be tax-free. Alternatively, you can contribute to a Roth IRA. For more information, visit: **www.icmarc.org/ira**.

Investment Control

A wide range of investment options are available to help you build a diversified portfolio. You control all investment decisions, including:

- How your contributions are invested
- How to manage your investments on an ongoing basis

Access to Your Money

Based on your employer's plan rules, withdrawals may be allowed while you're still working.

When you leave your employer, you can withdraw assets regardless of the reason and your years of service.

Enjoy flexible withdrawal options for vested assets like:

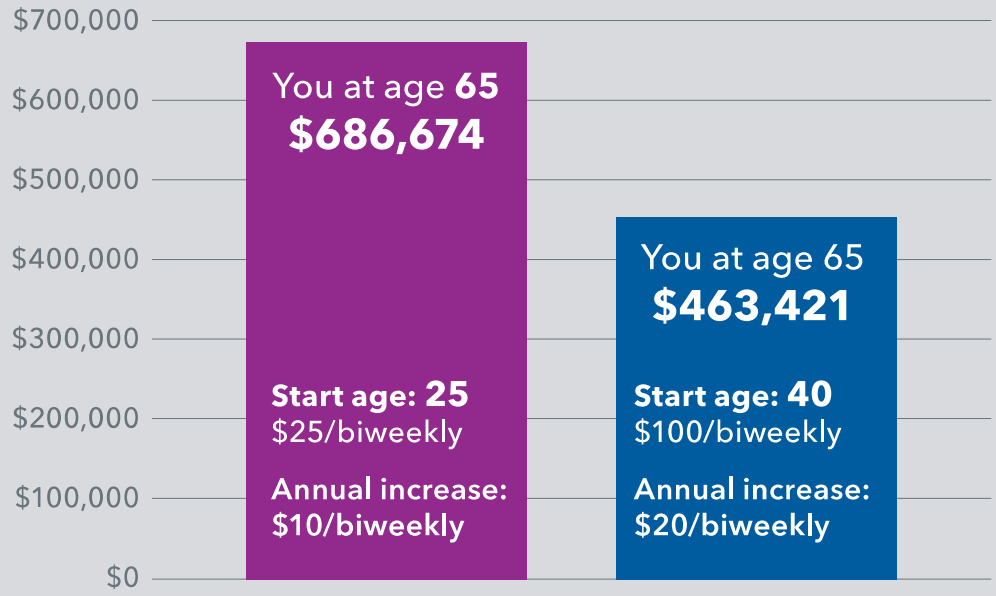
- Withdrawal of your entire balance
- Periodic, partial withdrawals as you see fit
- Installment payments of a certain dollar amount and frequency, such as monthly or quarterly, that you can change at any time
- Lifetime income payments

After you reach age 72 or separate from service, whichever is later, you'll be required to withdraw at least a minimum amount from your account each year, per IRS rules.

If plan rules and/or IRS rules allow, you can also borrow against your vested assets through a loan.

Don't delay, start saving today!

Saving now can help alleviate the pressure to catch up later. Starting early can give you an advantage due to compounding, in which your investments produce earnings from previous earnings.



For illustrative purposes only. Assumes an effective annual rate of 6%, compounded biweekly.

Designate Beneficiaries

You designate a beneficiary, or beneficiaries, to receive any remaining assets upon your death. Beneficiaries control investment decisions, receive the most flexible withdrawal options allowed by law, and aren't subject to any additional fees. If you don't designate beneficiaries, your estate is the default beneficiary, in which case:

- Assets may not be distributed per your wishes.
- Assets are subject to probate costs, potential delays, and creditor claims.
- Non-spouse heirs may receive fewer tax benefits.

Learn More

- Get to know your 457 plan: **www.icmarc.org/457**
- Log into your account to manage your savings and visit our Financial Wellness Center for 100+ interactive, fun, short videos, charts, calculators, articles, and tutorials. Get answers to your questions about debt, emergency savings, college tuition planning, investing, retirement planning, and much more: **www.missionsq.org**

MissionSquare RETIREMENT

Founded in 1972, MissionSquare Retirement helps those who serve their communities build toward a secure and confident financial future. MissionSquare is a mission-based, nonstock, nonprofit, financial services company that focuses on delivering results-oriented retirement plans, education, investments, and advice for over 1.6 million public participant accounts.*
To learn more, visit **www.missionsq.org**.

*As of December 31, 2021

ICMA-RC
Building Retirement Security

401

401 PLAN EMPLOYEE ENROLLMENT FORM - PAGE 1 OF 2

Complete this form to open an account with ICMA-RC by carefully reading the attached instructions and printing legibly in blue or black ink.

1. REQUIRED PERSONAL INFORMATION

Employer Plan Number **Employer Plan Name** **State**

10 _____ _____ _____

Social Security Number (for tax-reporting purposes) **Date of Birth** **Date Employed/Rehired†**

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ____ / ____ / ____ ____ ____ / ____ / ____ / ____ ____ ____ ____
Month Day Year Month Day Year

Full Name of Participant

_____
Last First M.I.

Mailing Address/Street

_____

City **State** **Zip Code**

_____ ____ _____

Job Title: _____ **Email Address:** _____

Daytime Phone Number **Evening Phone Number** **Gender** **Marital Status**

____ ___ / ___ ___ ___ / ___ ___ ___ ___ ____ ___ / ___ ___ ___ / ___ ___ ___ ___ ☐ M ☐ F ☐ Married ☐ Single
Area Code Area Code

†**EMPLOYER USE ONLY: Complete this portion if the participant is rehired.** Rehire? ☐ Check if yes Date of Initial Employment ____ ____ / ____ ____ / ____ ____ ____ ____

Date of Termination ____ ____ / ____ ____ / ____ ____ ____ ____ Vesting Percentage _____% Previous Months of Service _____

2. CONTRIBUTION AMOUNT

I authorize my employer to deduct (check all that apply):

NA ☐ ***Mandatory pre-tax**** deferrals of _____% or $_____ from my pay each pay period.

☐ ***Mandatory after-tax**** deferrals of _____% or $_____ from my pay each pay period.

*Mandatory deferral elections, if available, are irrevocable once made. Read Section 2 of the form instructions for more information.

NA ☐ ***Voluntary after-tax**** deferrals of _____% or $_____ from my pay each pay period.

NOTE: The following additional options are **available to 401(k) plans only**:

NA ☐ ***Elective pre-tax*** deferrals of _____% or $_____ from my pay each pay period.

☐ ***Roth**** deferrals of _____% or $_____ from my pay each pay period.

**NOT available to all plans. Check with your employer or ICMA-RC for availability.

For employer use: The employer will contribute 5% **% or $**_____. **The employee will contribute** _____**% or $**_____.

3. BENEFICIARY DESIGNATION

Please use whole percentages (e.g., 50%, not 33 ⅓%) and be sure the percentages total 100% when designating primary and contingent beneficiaries.

Primary Beneficiary(ies):

NAME	DATE OF BIRTH	RELATIONSHIP TO YOU*	SOCIAL SECURITY NUMBER (for tax-reporting purposes)	% OF BENEFIT (whole %)
	____/____/____		____-____-____	
	____/____/____		____-____-____	
	____/____/____		____-____-____	

Total = 100%

***The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.**

ICMA-RC
Building Retirement Security

401 PLAN EMPLOYEE ENROLLMENT FORM – PAGE 2 OF 2

401

Employer Plan Number 10 ____ ____ ____ ____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Name (Please Print) _____

3. BENEFICIARY DESIGNATION (CONTINUED)

Contingent Beneficiary(ies), if any:

NAME	DATE OF BIRTH	RELATIONSHIP TO YOU*	SOCIAL SECURITY NUMBER (for tax-reporting purposes)	% OF BENEFIT (whole %)
	____/____/____		____ - ____ - ____	
	____/____/____		____ - ____ - ____	
	____/____/____		____ - ____ - ____	
				Total = 100%

***The beneficiary relationship options are spouse, non-spouse, trust, estate, and charity.**

4. SPOUSAL CONSENT

If you are married, most 401 plans require your spouse to be the primary beneficiary for 100 percent of the account unless your spouse consents to waive this right. **Your spouse's written consent must be witnessed by your employer's plan representative or a notary public. Please read the instructions if you live in a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, or WI) and your 401 plan does not require spousal consent to name a non-spouse beneficiary.**

Spousal Consent (to be completed by the participant's spouse):

By signing below, I agree to waive my designation as sole primary beneficiary of my spouse's account. I understand the effect of this designation is to cause some or all of my spouse's death benefit to be paid to someone other than me and each beneficiary designation is not valid unless I consent to it.

_____ ___ ___ / ___ ___ / ___ ___ ___ ___
Signature of Participant's Spouse Month Day Year

_____
Print Name of Participant's Spouse

SPOUSAL CONSENT IS REQUIRED TO BE WITNESSED BY:

Employer's Plan Representative

Signature of Spouse witnessed this _____ day

of _____ (month), 20_____

_____
Employer Representative's Signature

_____
Print Name of Employer Representative

OR

Notary Public

Subscribed and sworn before me this _____ day of _____ (month), 20_____

_____
Notary Public's Signature

Notary Public SEAL _____ My commission expires _____

5. ALLOCATION OF CONTRIBUTIONS

Input the fund codes and allocation percentages (must total 100%) to show how contributions to your account will be invested. A list of funds and codes can be found on the Investment Options Sheet. Please read *Making Sound Investment Decisions: A Retirement Investment Guide* and the appropriate prospectus for full descriptions of the funds. For information on how assets will be invested in the absence of accurate and complete instructions, read Section 5 of the form instructions.

Note: Use whole percentages only.

EMPLOYER CONTRIBUTIONS				EMPLOYEE CONTRIBUTIONS			
Code	Percent	Code	Percent	Code	Percent	Code	Percent
			TOTAL = 100%				TOTAL = 100%

6. AUTHORIZED SIGNATURES

Submit this form to your employer promptly to avoid investment delay. If this form is faxed to ICMA-RC, please do not mail the original.

_____ ___ ___ / ___ ___ / ___ ___ ___ ___
Participant Signature Month Day Year

_____ ___ ___ / ___ ___ / ___ ___ ___ ___
Authorized Employer Official's Signature Month Day Year

2023- 2024 BENEFIT ELECTION AND ENROLLMENT FORM

Return via email to mhermes@winterspringsfl.org **Paper forms will not be accepted.**

(***This form must be returned even if you are declining/waiving ALL coverage.)***

Employee Name: _____ Date of Hire:_____

Personal Email: _____ Cell: _____

☐ **CHECK BOX TO KEEP ALL BENEFITS THE SAME.**
If you want ANY change to your benefits, do not check box and complete the entire benefit form AND list all benefits.

Employee ID: _____

Health- Pretax

Select your plan **and** coverage

Pick your Plan
- ○ Plan 6*
- ○ Plan 14
- ○ Decline

Pick your Coverage
- ○ Employee Only
- ○ Employee+Child(ren)
- ○ Employee+Spouse
- ○ Employee+Family

***For Plan 6, you also need to setup an HSA Account with a bank. Please add routing number and account number here, or attach a copy of a direct deposit authorization.**

Routing :_____

Account Number: _____

Dental- Pretax

Select your plan **and** coverage

Pick your Plan
- ○ PPO
- ○ DMO
- ○ Decline

Pick your Coverage
- ○ Employee Only
- ○ Employee+Child(ren)
- ○ Employee+Spouse
- ○ Employee+Family

Vision- Pretax

Select your plan **and** coverage

Pick your Plan
- ○ V1007
- ○ Decline

Pick your Coverage
- ○ Employee Only
- ○ Employee+Child(ren)
- ○ Employee+Spouse
- ○ Employee+Family

The City pays the premium for your Basic Life, Accidental Death & Dismemberment and Long Term Disability coverages. Please elect your coverage for additional Life, AD&D, and other voluntary benefits.

If no selection is made, you have declined ALL of these options.

- ○ **Dependent Life-** #298712- $10,000 Spouse/$5,000 Child(ren)
- ○ **Additional Voluntary Life-** #298705
  - ○ Additional Voluntary Life- Employee Coverage: $ _____ Bi-Weekly Premium: $ _____
  - ○ Additional Voluntary Life- Spouse Coverage: $ _____ Bi-Weekly Premium: $_____
  - ○ Additional Voluntary Life- Child(ren) Coverage: $ _____ Bi-Weekly Premium: $_____
- ○ **Additional AD&D-** #298705
  - ○ Additional Voluntary AD&D- Employee Coverage: $ _____ Bi-Weekly Premium: $ _____
  - ○ Additional Voluntary AD&D- Spouse Coverage: $ _____ Bi-Weekly Premium: $_____
  - ○ Additional Voluntary AD&D- Child(ren) Coverage: $ _____ Bi-Weekly Premium: $_____
- ○ **Short Term Disability-** #298706 **Bi-Weekly Premium: $**_____ **Refer to your benefit book for calculations**

Note: These plans may only be added during Open Enrollment. You may be asked to complete a health questionaire (Evidence of Insurability) in order to gain coverage. Coverage is not provided until you are approved by Unum.

Individual Voluntary Plans

These plans are only offered during Open Enrollment.

- ☐ Critical Illness Bi-Weekly Premium: $_____
- ☐ Accident Bi-Weekly Premium: $_____
- ☐ Hospital Indemnity Bi-Weekly Premium: $_____

	Employee	Employee & Spouse	Employee & Child/ren	Employee & Family
Health				
Plan 14	$ 66.42	$ 346.73	$ 346.73	$ 377.58
Plan 6	$ 10.00	$ 212.22	$ 212.22	$ 231.79
HSA	$ 50.00	$ 100.00	$ 100.00	$ 100.00
Dental				
DMO	$ 7.41	$ 14.82	$ 16.67	$ 26.82
PPO	$ 16.10	$ 32.18	$ 45.40	$ 62.37
Vision	$ 2.45	$ 4.90	$ 4.65	$ 7.30
Dependent Life	$ 1.03	$ 1.03	$ 1.03	$ 1.03
Accident				
With Rider	$ 9.95	$ 15.21	$ 18.59	$ 23.86
Without Rider	$ 8.19	$ 11.70	$ 15.60	$ 19.11

_____ _____

Signature Date

CITY OF WINTER SPRINGS
EMERGENCY CONTACTS

Employee Name: _____ Date:_____

In case of emergency, contact the following individuals:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Relationship: _____

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Relationship: _____

Note: Be sure to contact the Human Resources Department whenever any of this information changes, so that the system contains the most accurate, up-to-date contact information.

You can make changes by emailing employment@winterspringsfl.org or by calling (407) 327-8954.

For questions, contact Human Resources at (407) 327-8954

FLORIDA MUNICIPAL INSURANCE TRUST

FLORIDA LEAGUE OF CITIES
BENEFITS ENROLLMENT/CHANGE FORM

If you wish to enroll, waive, or make changes to your current medical or cafeteria plan benefits, you must complete an Enrollment Form. If you complete an Enrollment Form, it will supersede any other enrollment types.

☐ New Enrollment ☐ Status Change ☐ Add Coverage ☐ Term (reason) _____

Effective Date: _____ Date of Hire: _____

First name: _____ Middle name: _____ Last name: _____

Suffix: _____ Social Security Number: _____ Sex: ☐ M ☐ F Birth Date: ____/____/____

Address: _____

City/State: _____ Zip: _____Phone number: _____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed Email: _____

Employer Name: _City of Winter Springs _ Occupation: _____

MEDICAL PLAN

Select plan you wish to enroll or select "waive":

☐ UHC Plan 6
☐ UHC Plan 14
☐ WAIVE

Select Tier of coverage desired:

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

DEPENDENT INFORMATION

Social Security Numbers are required for all listed dependents to ensure they will be added to your selected coverage.

Please refer to each plan's eligibility guidelines to determine if your dependent is eligible.

FMIT
FLORIDA MUNICIPAL INSURANCE TRUST

DEPENDENT 1:

First name: _____ Middle name: _____ Last name: _____

Suffix: _____ Social Security Number: _____ Gender: ☐ M ☐ F

Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child Birth date: _____/_____/ _____ Coverage

Selected: ☐ Medical ☐ Dental ☐ Vision

FOR DEPENDENT CHILDREN ONLY (AGE 26 to 30)

Disabled ☐ Yes ☐ No

FL Resident ☐ Yes ☐ No

Student full or part time ☐ Yes ☐ No

Unmarried & no children ☐ Yes ☐ No

Uninsured/not eligible for Medicare ☐ Yes ☐ No

DEPENDENT 2:

First name: _____ Middle name: _____ Last name: _____

Suffix: _____ Social Security Number: _____ Gender: ☐ M ☐ F

Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child Birth date: _____ /_____ /_____

Coverage Selected: ☐ Medical ☐ Dental ☐ Vision

FOR DEPENDENT CHILDREN ONLY (AGE 26 to 30)

Disabled ❑ Yes ❑ No

FL Resident ❑ Yes ❑ No

Student full or part time ❑ Yes ❑ No

Unmarried & no children ❑ Yes ❑ No

Uninsured/not eligible for Medicare ❑ Yes ❑ No

DEPENDENT 3:

First name: _____ Middle name: _____ Last name: _____

Suffix: _____ Social Security Number: _____ Gender: ☐ M ☐ F

Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child Birth date: _____ /_____ /_____

Coverage Selected: ☐ Medical ☐ Dental ☐ Vision

FOR DEPENDENT CHILDREN ONLY (AGE 26 to 30)

Disabled ❑ Yes ❑ No

FL Resident ❑ Yes ❑ No

Student full or part time ❑ Yes ❑ No

Unmarried & no children ❑ Yes ❑ No

Uninsured/not eligible for Medicare ❑ Yes ❑ No

DEPENDENT 4:

First name: _____ Middle name: _____ Last name: _____

Suffix: _____ Social Security Number: _____ Gender: ☐ M ☐ F

Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child Birth date: _____ /_____ /_____

Coverage Selected: ☐ Medical ☐ Dental ☐ Vision

FOR DEPENDENT CHILDREN ONLY (AGE 26 to 30)

Disabled ❑ Yes ❑ No

FL Resident ❑ Yes ❑ No

Student full or part time ❑ Yes ❑ No

Unmarried & no children ❑ Yes ❑ No

Uninsured/not eligible for Medicare ❑ Yes ❑ No

FLORIDA MUNICIPAL INSURANCE TRUST

On the day this policy begins, will you or any of your covered dependents be active under any other medical health plan or policy including Medicare? ☐ Yes ☐ No If yes, complete the appropriate section(s) below. If additional space is required, attach a separate sheet with additional information.

Medical Coverage	Medicare
Insured's name & Date of Birth	Insured's name & Date of Birth
Employment Status: ☐ Active ☐ Retired	Entitlement Reason: ❑ Age 65 or older ❑ End Stage of Renal Disease ❑ Other Disability
Policy #: Effective Date:	Member HIC Number:
Name of Insurance Company:	Part A Effective Date:
List names of "all" family members that were covered:	Part B Effective Date:

WAIVER OF GROUP BENEFITS

I hereby certify that I have been given an opportunity to enroll for Group Benefits as offered by my employer, and after careful consideration I have decided not to take advantage of this offer. It is my understanding that in the event I desire such coverage, hereafter, I shall be required to furnish evidence of insurability satisfactory to the trust and that the trustees reserve the right to refuse to grant such coverage.

REASON FOR DECLINE IS_____

Employee Signature: _____ Date: _____

I understand that I cannot change the amount of the payroll deduction or revoke this agreement during the plan year unless there is a valid change in status as defined by IRS Section 125 Guidelines. I understand and agree that my employer, union, benefits administrators, and contract administrators will be held harmless from any liability resulting from either my participation in flexible benefits or my failure to sign or accurately complete this enrollment form.

Employee Signature: _____ Date: _____

The following statement is being provided to you by Florida Municipal Insurance Trust Insurance in compliance with Section 119.071(5), Florida Statutes regarding collection of social security number by public agencies in the State.

THE FLORIDA MUNICIPAL INSURANCE TRUST COLLECTS YOUR SOCIAL SECURITY NUMBER FOR THE FOLLOWING PURPOSES: INSURANCE AND WORKER'S COMPENSATION ADMINISTRATION; IDENTIFICATION AND VERIFICATION; DATA COLLECTION, RECONCILIATION AND PROCESSING; AND TAX REPORTING. SOCIAL SECURITY NUMBERS ARE ALSO USED AS A UNIQUE NUMERIC IDENTIFIER AND MAY BE USED FOR SEARCH PURPOSES.

OFFICIAL USE ONLY

Entry Date:	Effective date:	Staff:	Group #:

CITY OF WINTER SPRINGS
HSA CONTRIBUTION

Request Date:

☐ I would like to have $____.__ deducted (pretax) from each paycheck and deposited in my HSA account.

☐ I would like to change my current payroll deduction. The new amount that I would like to have deducted (pretax) from each paycheck and deposited into my HSA account is: $____.__

☐ I would like to cancel my current contribution to my HSA account.

Please note, HSA contribution adjustments will become effective the first pay date following 14 days from your request.

_____
Employee Name (Print)

_____ _____
Employee Signature Date

BENEFICIARY DESIGNATION FORM
GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT
CRITICAL ILLNESS AND ACCIDENT INSURANCE
Unum Life Insurance Company of America
Unum Insurance Company
Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI) | Social Security Number

Policy Number(s) | Division Number(s)

Employer Name | Check the coverages listed below to which this beneficiary designation applies:
☐ Basic Life ☐ Critical Illness ☐ Accident
☐ Supplemental Life ☐ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

1. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)
2. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)
3. Name: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Date of Birth: _____ Telephone: _____
   Social Security Number: _____
   Email address: _____
   Percentage: _____ (Total must equal 100% between all beneficiaries)

BENEFICIARY DESIGNATION FORM
GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT
CRITICAL ILLNESS AND ACCIDENT INSURANCE

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

1. Name: _____

   Street: _____

   City: _____ State: _____ Zip: _____

   Date of Birth: _____ Telephone: _____

   Social Security Number: _____

   Email address: _____

   Percentage: _____ (Total must equal 100% between all beneficiaries)

2. Name: _____

   Street: _____

   City: _____ State: _____ Zip: _____

   Date of Birth: _____ Telephone: _____

   Social Security Number: _____

   Email address: _____

   Percentage: _____ (Total must equal 100% between all beneficiaries)

3. Name: _____

   Street: _____

   City: _____ State: _____ Zip: _____

   Date of Birth: _____ Telephone: _____

   Social Security Number: _____

   Email address: _____

   Percentage: _____ (Total must equal 100% between all beneficiaries)

SECTION 4: Signature

X _____ _____

Employee Signature **Date**

Important Information About Designation of Beneficiaries

Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits only if **all** primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- **Minor Beneficiary(ies) –** When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- **Trust –** You may designate a valid trust as a beneficiary.

Types of Coverage Information

- **Basic Life** is life insurance provided by your employer for which they pay the premiums.

- **Supplemental Life** is life insurance elected by you for which you pay the premiums.

- **AD&D** is Accidental Death & Dismemberment coverage.

- **Critical Illness** is insurance elected by you for which you pay the premium.

- **Accident** is insurance elected by you for which you pay the premiums.

- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- **Updates to Your Beneficiary Designation –** You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- **Consult an Attorney –** This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

Nationwide®

Nationwide Retirement Solutions Participation Agreement

for 457(b) and 401(a) Plans

Personal Information

457(b) Employer Name:	457(b) Employer ID:
401(a) Employer Name:	401(a) Employer ID:
Name:	Social Security Number:
Date of Birth:	Date of Hire:
Address:	City, State, & ZIP:
Home Phone Number:	Work Phone Number:
Email Address:	Gender: ☐ Male ☐ Female
How would you like to be contacted if additional information is required? ☐ Telephone ☐ Email	

Paperless Delivery Consent

Paperless Delivery: By providing your email address you are consenting to receive statements, confirmations, terms, agreements and other information provided in connection with your retirement plan electronically. Unless you choose to have statements, account documents and other documents sent in connection with your retirement plan delivered via US Mail to the mailing address of record by checking the box below, these documents will be made available to you electronically.

☐ **I wish to receive my statements and account documents via US Mail.**

Contribution Summary & Payroll Frequency

	Dollar Amount* **OR** Percentage*	
Contribution Amount - 457(b) Pre-Tax	$	%
Contribution Amount - 457(b) Roth**	$	%
Contribution Amount - 401(a) Pre-Tax Employee Mandatory Contribution***	$	%
Total	**$**	**%**

Payroll Frequency: ☐ Weekly ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Other: _____

NOTE: All increases, decreases and suspensions will be implemented no sooner than the first payroll of the month following the change. Please remember to check your paystub to confirm your selected contributions are accurately reflected and being processed.

* **Percentage contributions must be in whole percentages.** Check with your employer on whether your plan offers deferrals in percentages, dollar amounts or both.

**May not be offered by your plan. Roth contributions are made on an after-tax basis.

***Employee Mandatory Contribution (401(a) only) is a one time election stated in the Plan Document. This election is irrevocable and must be made before the participant's first entry date.

Automatic Contribution Increase (This election is voluntary and is only available if permitted by your plan.)

☐ **I wish to participate in an annual automatic contribution increase.**

☐ **I wish to stop my annual automatic contribution increase.**

Money Source	Dollar Amount Increase	Percentage Increase
457(b) Pre-Tax	$	%
457(b) Roth	$	%

Increase Contribution Annually on: _____(MM/DD)

If selected, this increase will automatically occur annually as soon as administratively feasible for the date selected below. Increases can only occur for money source(s) (Pre-Tax and/or Roth) and mode(s) ($ or %) that you are currently contributing. Please do not select a date of 02/29; if selected, Nationwide will process on 02/28.

Additional information regarding the automatic contribution increase option can be found in the attached Memorandum of Understanding.

Beneficiary Designation

☐ **Check here if this is a change of beneficiary.** (Beneficiaries listed below replace any prior designation)
PLEASE NOTE: Percentage split must total 100% for each category of beneficiary.
If additional space for beneficiaries is required, attach additional sheets and mark this box: ☐

Additional information to assist you in completing your beneficiary designations can be found in the attached Memorandum of Understanding.

Primary Beneficiary(ies) (must total 100%):

Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:
Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:
Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:
Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:
Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:

Total = 100%

Contingent Beneficiary(ies) (must total 100%):

Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:
Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:
Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:
Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:
Name:	Relationship:	Social Security #:	Phone #:
Address:		Date of Birth:	% Split:

Total = 100%

Funding Options

Pre-tax and Roth contributions will use the same investment options and allocation. If you wish to have different selections, contact a Customer Service Representative at 1-877-677-3678.

Nationwide® Target Destination Series

_____% Nationwide® Destination 2015 Fund (Institutional Service Class)
_____% Nationwide® Destination 2020 Fund (Institutional Service Class)
_____% Nationwide® Destination 2025 Fund (Institutional Service Class)
_____% Nationwide® Destination 2030 Fund (Institutional Service Class)
_____% Nationwide® Destination 2035 Fund (Institutional Service Class)
_____% Nationwide® Destination 2040 Fund (Institutional Service Class)
_____% Nationwide® Destination 2045 Fund (Institutional Service Class)
_____% Nationwide® Destination 2050 Fund (Institutional Service Class)
_____% Nationwide® Destination 2055 Fund (Institutional Service Class)
_____% Nationwide® Destination 2060 Fund (Institutional Service Class)

Nationwide® Investor Destinations Series

_____% Nationwide® Investor Destinations Aggressive Fund (Service Class)
_____% Nationwide® Investor Destinations Moderate Aggressive Fund (Service Class)
_____% Nationwide® Investor Destinations Moderate Fund (Service Class)
_____% Nationwide® Investor Destinations Moderate Conservative Fund (Service Class)
_____% Nationwide® Investor Destinations Conservative Fund (Service Class)

International

_____% American Century International Discovery Fund (Investor Class)**
_____% Invesco International Growth Fund (Class R5)**
_____% MFS International Value Fund (Class R3)**
_____% Nationwide® International Index Fund (Class A)
_____% Oppenheimer Global Fund (Class A)

Small Cap

_____% Nationwide® Variable Insurance Trust: Nationwide Multi-Manager NVIT Small Company Fund (Class 1)
_____% Nationwide® Small Cap Index Fund (Class A)
_____% Nationwide® Small Company Growth Fund (Institutional Service Class)
_____% Nationwide® U.S. Small Cap Value Fund (Institutional Service Class)

Mid Cap

_____% American Century Vista Fund (Investor Class)**
_____% American Funds-The Growth Fund of America** (Class A)
_____% JP Morgan Mid Cap Value Fund (Class A)
_____% Nationwide® Diverse Managers Fund (Institutional Service Class)
_____% Nationwide® Mid Cap Market Index Fund (Class A)
_____% Neuberger Berman Equity Funds ® - Genesis Fund (Trust Class)
_____% Wells Fargo Advantage Funds - Discovery Fund (Administrator Class)**

Large Cap

_____% American Century Growth Fund (Investor Class)
_____% American Century Value Fund (Investor Class)
_____% Dreyfus Appreciation Fund Inc.
_____% Dreyfus S&P 500 Index Fund
_____% Fidelity Contrafund**
_____% Fidelity Equity-Income Fund**
_____% Nationwide® Fund (Institutional Service Class)
_____% Nationwide® Growth Fund (Institutional Service Class)
_____% Nationwide® Large Cap Growth Portfolio
_____% Nationwide® S&P 500 Index Fund (Institutional Service Class)
_____% Neuberger Berman Equity Trust Socially Responsive Fund (Investor Class)
_____% T. Rowe Price Growth Stock Fund (Advisor Class)
_____% INVESCO Growth & Income Fund (Class A)**

Balanced

_____% American Funds-The Income Fund of America**

Bonds

_____% MFS High Income Fund (Class A)
_____% Nationwide® Bond Index Fund (Class A)
_____% Nationwide® HighMark Bond Fund (Institutional Service Class)
_____% PIMCO Total Return Fund (Class A)
_____% Waddell & Reed Advisor High Income Fund (Class Y)

Fixed/Cash

_____% Federated U.S. Government Securities Fund: 2-5 Years** (Institutional Shares)
_____% Nationwide® Money Market Fund (Prime Shares)*
_____% Nationwide® Fixed Account
_____% Morley Stable Value Retirement Fund*

100% Total for both columns must equal 100%

* This fund is a non-annuity fund and may not be available in your plan. Please contact the Public Sector Service Center at www.nrsforu.com or at 1-877-NRS-FORU (1-877-677-3678), or your local retirement specialist for details.

** This fund may not be available in your plan. Please contact the Public Sector Service Center at www.nrsforu.com or 1-877-NRS-FORU (1-877- 677-3678) or your local retirement specialist for details.

Authorization

☐ Please send me a copy of the Informational Brochure/Prospectus(es).
☐ Please contact me regarding transferring my other pre-tax retirement plans.
☐ Please send me forms regarding the Catch-Up Provision.

I authorize my Employer to make the contribution(s) to the Plan in the amounts I have designated above. The contribution(s) will continue until otherwise authorized in accordance with the Plan. The withholding of my contribution(s) amount by my Employer and its payment to the designated investment option(s) will be reflected in the first pay period contingent on the processing of this application by the Public Sector Service Center in conjunction with the set-up time required by my payroll center. The contribution(s) is to be allocated to the funding options in the percentages indicated above. I understand some investment options may impose a short-term trading fee. I understand I should read the fund prospectuses carefully.
I have read and understand the terms contained in this form, including the attached Memorandum of Understanding, which is incorporated herein.
I accept these terms and understand that these terms do not cover all the details of the Plan or products.

Participant Signature:	Date:
Retirement Specialist Name (Print):	Agent #:

Things To Remember

☐ Complete all of the sections on the Participation Agreement that apply to your request.

☐ Remember to have the allocation of your funding options total 100%, in whole percentages, when completing the Funding Options section. If allocations do not total 100%, the remaining amounts will be considered to be not in good order, and you agree they will be allocated to the Nationwide® Money Market Fund (Prime Shares).

☐ For your beneficiary designation, the percentage split must total 100% for each category of beneficiary.

☐ Complete the Authorization section, and remember to sign and date this Participation Agreement.

☐ Enclose the completed Participation Agreement, and any other documentation in the business reply envelope included with this booklet.

☐ Your Plan may permit you to contribute additional funds as a "catch-up" contribution during the last three years preceding the normal retirement age under the Plan. If you would like to receive paperwork to take advantage of the catch-up provision, please check the appropriate box in the authorization section on page four.

☐ Your employer will specify the amount of 414(h) Pickup contributions (401(a) only). Generally, these contributions are expressed as a percentage of pay. If an amount is specified, all eligible employees are required, as a condition of employment to make this contribution.

Form Return

Mail: Nationwide Retirement Solutions
PO Box 182797
Columbus, OH 43218-2797

Fax: 877-677-4329

Please note that the information provided on this Participation Agreement will supercede any prior information provided, such as allocations, contribution amounts, contribution types (except Mandatory Employee Contribution) and/or beneficiary information.

Nationwide®

Memorandum of Understanding

The purpose of the Memorandum of Understanding is to make you aware of some of the highlights, restrictions and costs of your Plan. It is not intended to cover all the details of the Plan and should not be relied upon in making decisions about Plan benefits. You should refer to the Plan Document for specific details about the Plan's provisions and the prospectuses and other documentation for the Plan's underlying investment options.

457(b) PLANS

1. The total annual contribution amount to all 457(b) plans is the lesser of the maximum annual 457(b) contribution limit or 100% of the participant's includible compensation. This amount may be adjusted annually. More information on the maximum contribution limits can be found at www.irs.gov. Under certain circumstances, additional amounts above the limit may be contributed to the Plan if (1) the participant attains age 50 or older during the current calendar year, or (2) the participant is within three years of the Plan's Normal Retirement Age and did not contribute the maximum amount to the 457(b) Plan in prior years. The Plan Document provides additional details about contribution limits. Contributions in excess of maximum amounts are not permitted and will be reported as taxable income when refunded. It is the participant's responsibility to ensure contributions to all 457(b) plans in which the participant participates, regardless of employer, do not exceed the annual limit.
2. Enrollment or contribution changes cannot be effective prior to the first day of the month following receipt of the participant's request. The employer's processing schedule will determine the actual effective date of the contribution. It is the Plan Sponsor's/Pay Center's responsibility to ensure deferrals do not commence too early.
3. If the Plan permits designated Roth contributions, these contributions are made on an after-tax basis, which means they will not be subject to income taxes when distributed at a later time. As opposed to the withdrawal of earnings on pre-tax contributions, though, the earnings on designated Roth contributions are generally not subject to future taxes as long as the distribution from the Roth account satisfies the requirements to be a "qualified distribution." In order to be a qualified distribution, the distribution must be made five or more years after January 1 of the first year the participant made Roth contributions to the Plan and must be made on or after the attainment of age 59½, the participant's death, or the participant's disability. If the participant previously established another designated Roth account in another plan and is able to roll the funds from this Plan to the other plan, the five-year period would begin to run from January 1 of the year of the first contribution to a designated Roth account. A non-qualified Roth distribution may result in an additional 10% early withdrawal tax on the portion of the distribution includible in gross income if made from rollovers to this Plan from a qualified plan or a 403(b) plan, and no statutory exceptions apply. Please note that once made, contributions and/or rollovers to a Roth account may not be reversed. In the event the participant desires to make contribution changes, only future contributions and/or rollovers can be redirected (contributed as pre-tax funds).
4. The Plan Document governs when distributions may be made from the Plan. In general, distributions may be made from a 457(b) plan only upon separation from service, upon attainment of age 70½, or upon the death of the participant. Section 457(b) plans can also permit withdrawals from the Plan (even if the participant is still employed) in cases of an unforeseeable emergency approved by the Plan; when taking a loan, or for a one-time in-service withdrawal if the participant's account value is $5,000 or less and the participant has not contributed to the Plan for two or more years. All withdrawals of funds must be in compliance with the Internal Revenue Code (the "Code") and any applicable regulations as well as the Plan Document, which the participant should consult to confirm which distribution opportunities are available.
5. Contributions, in the form of salary reductions, will be made until I notify NRS or my Plan Sponsor otherwise. Once notification is received, salary reductions will be changed as soon as administratively feasible. NRS will invest contributions received from the Plan Sponsor as soon as administratively feasible.

401(a) PLANS

1. The annual defined contribution plan limit to all 401(a) plans is the lesser of the IRS maximum 415 limit, or 100% of my eligible compensation. This amount may be adjusted annually. More information on the maximum contribution limits can be found at www.irs.gov. Current or future participation in additional retirement plans, such as 403(b) and/or 401(a) plans, may affect the maximum annual contribution limit under this 401(a) plan.
2. The Plan Document governs when distributions may be made from the Plan. In general, distributions may be made only upon separation from service or upon the death of the participant. Some plans may also permit distribution upon reaching normal retirement age as defined in the Plan Document, upon a financial hardship approved by the Plan, upon disability or when taking a loan. All withdrawals of funds must be in compliance with the Code and any applicable regulations as well as the Plan Document, which the participant should consult to confirm which distribution opportunities are available. An additional early withdrawal tax of 10% may apply in some circumstances. It is strongly recommended that the participant consult with his/her tax advisor prior to requesting a distribution.
3. 414(h) Mandatory Employee Contributions – Your employer will specify the amount of these contributions if they are required by the Plan. Generally, these contributions are expressed as a percentage of pay. If an amount is specified, all eligible employees are required, as a condition of employment, to make this contribution to the Plan. These contributions will not be included in your taxable gross income; however, they do come out of your paycheck. The tax on these contributions will be deferred until benefits are distributed. Other plans may permit the participant to make a one time irrevocable election to contribute a percentage of compensation to the Plan prior to his/her Plan entry that cannot be modified later. The participant should consult the Plan Document for specific contribution provisions.

ALL PLANS

1. Participation in any of the employer's plans is governed by the terms and conditions of the Plan Document which should be consulted for plan details. Fund prospectuses are available upon request at www.nrsforu.com or by calling 1-877-NRS-FORU (1-877-677-3678).

2. Generally, distributions from the Plans must begin no later than the 1st of April following the later of the year the participant reaches age 70½ or separates from service. The Plan Document should be consulted for further details. Generally, all pre-tax distributions are taxable as ordinary income and are subject to income tax in the year received. Plan distributions must be made in a manner that satisfies the minimum distribution requirements of Code section 401(a)(9), which currently requires benefits to be paid at least annually over a period not to extend beyond the participant's life expectancy. Failure to meet minimum distribution requirements may result in the participant being subject to a 50% federal excise tax.
3. Any beneficiary designation I made on this form will supersede any prior beneficiary designation and shall become effective on the date accepted by the Plan, provided that this designation is accepted by the Plan prior to my death. Further, any benefits payable at my death shall be paid in substantially equal shares to my beneficiaries unless I specify otherwise. My death benefits will be paid first to my Primary Beneficiaries. If any of my Primary Beneficiaries predecease me, then my death benefits will be paid to the remaining Primary Beneficiaries. Contingent Beneficiaries will only receive benefits if no Primary Beneficiary survives me. If no beneficiary designation is on file, benefits will be paid as set forth in the Plan Document. If I participate in both a 457(b) plan and a 401(a) plan administered by NRS, I understand my beneficiary designations made on this form will apply to both plans unless I have indicated otherwise.
4. Disclaimer for Community and Marital Property States: If the participant resides in a community or marital property state, the participant's spouse may have a property interest in the participant's Plan account and the right to dispose of the interest by will. Therefore, NRS disclaims any warranty as to the effectiveness of the participant's beneficiary designation or as to the ownership of the account after the death of the participant's spouse. For additional information, please consult your legal advisor to learn more about how your beneficiary designation may be affected by community or marital property state law.
5. Participants must notify NRS of any address changes, beneficiary changes, contribution changes, allocation changes or errors on the participant's account statement.
6. Participants will receive a statement of their account quarterly.
7. All Plan transactions initiated using the telephone will be recorded for the participant's protection.

INVESTMENT OPTIONS

1. Participant contributions will be invested pursuant to the participant's selection of funding options specified on the Participation Agreement.
2. NRS will permit participants and beneficiaries to exchange amounts among the Variable and Fixed investment options as frequently as permitted by the Plan, subject to the limits and rules set by each Fund and the Annuity Contracts. Changes may be made by calling 1-877-NRSFORU or by logging on to www.nrsforu.com. Investment options may be periodically changed or restricted, and may vary by the source of the money invested.
3. Transfers between investment options are provided for under the Plan subject to limitations or restrictions (including redemption fees), if any, as imposed by the investment providers. Some mutual funds may also impose a short term trading fee. I understand that any information regarding limitations or restrictions as they apply to the Plan may be obtained from the Plan Administrator. Participants should read the underlying mutual fund prospectuses carefully.
4. The Net Asset Value of a mutual fund changes on a daily basis and there is no guarantee of principal or investment return.
5. If the participant selects an investment option that is closed or unavailable, the money will be invested in the Nationwide Money Market Fund, which is the default investment option. If participants elect a total investment allocation percentage that is less than 100%, the difference will be invested in the Nationwide Money Market Fund. If the participant elects a total investment allocation percentage greater than 100%, the deferral election will be rejected and the participant's investment option selections will not be processed.
6. The Plan may impose a Plan administration fee or investment management fees. Fees can vary depending on the mutual funds in which the participant invests. For more information regarding fees, please call 1-877-NRS-FORU (1-877-677-3678).

NATIONWIDE LIFE FIXED ACCOUNT

1. A guaranteed interest rate is declared quarterly and credited daily, which is not lower than the minimum annual rate.
2. Nationwide may earn a spread on assets held in the Nationwide Fixed Account, which is reflected in the crediting rate. The spread represents the difference between what Nationwide earns on investments and what it credits to the Fixed Account as interest.
3. Exchanges or transfers may be made based upon one of the following options as chosen by your employer:
   a) Exchanges and/or transfers of money from the Fixed Account may be made no more than twice a year and may not exceed 20% of the participant's Fixed Account value. Once the 20% limit has been reached, no further exchanges/transfers will be permitted out of the participant's Fixed Account during the remainder of the calendar year. If the Fixed Account value is less than or equal to $1,000, the participant can exchange/transfer up to the entire account value. Each exchange/transfer will count toward the limitation of two exchanges/transfers out of the Fixed Account per year. Additionally, a five-year Exchange/Transfer election allows for the systematic movement of 100% of the participant's account value out of the Fixed Account on a monthly basis over a five-year period. If elected, the participant cannot defer, exchange, or transfer into his/her Fixed Account during the five-year term without canceling this election.

   -OR-

   b) Exchanges and/or transfers from the Fixed Annuity may be made up to 100% of the participant's account value. The total of all participant exchanges and/or transfers cannot exceed 12% of the total amount held in the Deposit Fund for the employer under the Fixed Account as of December 31 of the previous calendar year. Once this aggregate limit is met, no further exchanges or transfer into any participant's Fixed Account will be permitted.

   Exchange: An exchange is the movement of money between the Nationwide Life Fixed Account and Variable Annuity options and/or between funds in the Variable Annuity option.

   Transfer: A transfer is the movement of money between product providers within the same plan.

Memorandum of Understanding

NATIONWIDE LIFE VARIABLE ANNUITY CONTRACT

1. I understand that a Variable Account Charge is deducted daily from the Variable Account. The Variable Account Charge is deducted daily in an amount not to exceed the following schedule:

Plan Assets	Variable Account Charge
0 - $10 million	0.95%
$10 - $25 million	0.90%
$25 - $50 million	0.80%
$50 - $100 million	0.65%
$100 - $150 million	0.50%
$150 million	0.40%

2. I understand that retirement income payments and termination values (if any), provided by the contract are variable when based on the investment experience of a separate account and are not guaranteed as to the dollar amount.

AUTO INCREASE

I understand that the participant elected automatic contribution increase option is only available if offered by the Plan and, if offered, will not take place until I elect this option. By selecting the participant elected automatic contribution increase option, my payroll contributions will automatically increase annually for the money source(s), the date and by the dollar or percentage amount selected. I may stop the participant elected automatic contribution increase at any time by calling 1-877-677-3678 completing a new Participation Agreement, or accessing www.nrsforu.com. Increase requests that do not match the current source and mode as I am currently contributing will not be processed. A selected date of 02/29 will not be processed, and will be changed to 02/28.

MUTUAL FUND PAYMENTS DISCLOSURE

Nationwide Retirement Solutions, Inc. and its affiliates (Nationwide) offer a variety of investment options to public sector retirement plans through variable annuity contracts and trust or custodial accounts. Nationwide may receive payments from mutual funds or their affiliates in connection with those investment options. For more detail about the payments Nationwide receives, please visit www.nrsforu.com.

ENDORSEMENT DISCLOSURE

Nationwide Retirement Solutions, Inc. and Nationwide Life Insurance Company have endorsement relationships with the National Association of Counties and the International Association of Firefighters Financial Corporation. More information about the endorsement relationships may be found online at www.nrsforu.com.

CONSENT TO ELECTRONIC PAPERLESS DELIVERY AND ACCESS

By providing your email address here, you are agreeing and consenting to receive and view plan benefit statements, correspondence and confirmations, and other communications electronically. These materials will be provided through an email message notifying you that electronic documents are available online for you to view and print. This replaces all written communication associated with your Retirement Plan(s) serviced by Nationwide and you will no longer receive these documents via U.S. Mail. By providing your consent to electronic delivery, you are acknowledging and confirming that you are consenting to receive Plan Communications electronically, as they are now available or as they may be required or become available in the future and that you have access to view and print your documents electronically from the website and to save them from your computer or other electronic device. If you would like to receive the above referenced documents in paper form via U.S. Mail you can do so by contacting Customer Service at (877-677-3678) and requesting paper. You may opt out of electronic delivery of your plan related documents at any time. There is no additional cost to receive documents in paper format via U.S. Mail.

CHANGING YOUR EMAIL ADDRESS AND YOUR PAPERLESS DELIVERY PREFERENCES

You are able to update your email address or change your Paperless Preferences anytime either on the website or via Customer Service.

YOUR RIGHT TO REVOKE CONSENT

You have the right to revoke your consent to receive documents electronically. Your consent shall be effective until you revoke it by changing your delivery preferences via Customer Service or on the website by selecting U.S. Mail delivery.

Nationwide®

City of Winter Springs
DEFINED BENEFIT PENSION PLAN
BENEFICIARY DESIGNATION

If you have been legally married for at least one (1) year prior to the date of your death, federal law now requires that your spouse be the sole beneficiary of your death benefits under the plan. You may designate someone other than your spouse as beneficiary only if your spouse consents to the designation before a notary public, as provided below. If you later change your beneficiary, you must complete a new designation form and your spouse must again give written consent. In the event of dissolution of marriage, remarry, any non-spouse designation of beneficiary will require the written consent of your new spouse. If more than one beneficiary is named as either primary or contingent, please specify percentage.

Primary Beneficiary (Include Address, Relationship, Date of Birth, Social Security#)

_____

Contingent Beneficiary (Include Address, Relationship, Date of Birth, Social Security#)

_____

EXECUTED this _____ day of _____2_____.

WITNESSES:

_____
Witness Signature

_____
Witness Signature

PARTICIPANT (Employee):

_____
Employee Name (Type or Print)

_____
Employee Signature

SPOUSE'S CONSENT TO BENEFICIARY DESIGNATION

I hereby consent to the above beneficiary designation by my spouse as a participant in the above referenced plan, to have the death benefits under the Plan paid to the beneficiary(ies) specified in the designation. I acknowledge that I understand fully that (1) the effect of the above designation is to cause my spouse's benefit under the Plan to be paid to a beneficiary other than me upon my spouse's death; (2) if I do not consent the death benefit will be paid to me; (3) no such beneficiary designation is valid unless I consent to it; and (4) my consent is irrevocable unless my spouse revokes the above beneficiary designation.

EXECUTED this _____day of_____2_____.

PARTICIPANT'S (Employee) SPOUSE:

_____
Spouse Signature

On this day personally appeared_____, to me known to be the person described in and who executed the foregoing Spouse's Consent to Beneficiary Designation.

_____
Notary Signature

NOTE: If you have named someone other than your spouse as primary beneficiary and the aforesaid Spouse's Consent to Beneficiary Designation has not been signed, you must certify below that you are not married.

I hereby certify that I was not married on the date set forth in the above Beneficiary Designation.

PARTICIPANT (Employee):

_____
Employee Signature