2024-2025
City of Pembroke Pines
Benefit Guide

Table of Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see your page 60 for more details.

Welcome to your 2024-2025 Benefit Guide

The City of Pembroke Pines is proud to serve you and your family through our 2024-2025 Health and Welfare Benefits Plan. We understand that our employees have diverse needs, and so we have developed a well-rounded plan capable of helping to protect you and your family members in the case of illness or injury.

This Benefits Information Guide provides necessary plan and program information to help you understand your many benefit options and ultimately enroll in the benefits that work best for you and your family for the 2024-2025 Plan Year. We hope that our guide can be an effective and comprehensive resource while you consider your benefit elections.

This document contains a summary in English of information about your upcoming benefits enrollment. If you have difficulty understanding any part of this document, contact Human Resources at 954-392-2090.

Benefit Offering Directory

MEDICAL	CONTACT
UMR Plan 1 **UMR** Plan 2 Group #7670-00-510020	1-800-362-1116 www.umr.com
OptumRx Pharmacy Group #1960498	**OptumRx:** 1-877-559-2955
Teladoc Telemedicine	**Teladoc:** 1-800-835-2362 www.teladoc.com
DENTAL	
Delta Dental DHMO **Delta Dental** PPO 1250 **Delta Dental** PPO 5000	1-800-521-2651 www.deltadental.com
VISION	
The Standard VSP Vision	1-800-877-7195 www.standard.com/services
LIFE & DISABILITY	
The Standard Basic Life & AD&D **The Standard** Voluntary Life & AD&D **The Standard** Voluntary Long-Term Disability	1-800-628-8600 www.standard.com
VOLUNTARY BENEFITS	
Diversified Administration Flexible Spending Accounts (FSAs)	**FSA:** 954-983-9970 www.div125.com
Resources for Living Employee Assistance Program (EAP)	**EAP:** 1-800-865-3200 www.resourcesforliving.com Login: Pembroke Pines FL Password: EAP
AFLAC Short-Term Disability **AFLAC** Accident Indemnity **AFLAC** Cancer Indemnity **AFLAC** Critical Care and Recovery	**AFLAC Voluntary Products**: Gene Villa 561-714-4224 gene@definovilla.com

Benefit Enrollment Information

Making Plan Changes

Existing employees can only make plan changes during the Open Enrollment window and cannot make additional changes to your coverage during the year unless you experience a qualified family status change. Below, we have included a few examples of qualified family status change events:

Special Enrollment Events (Add coverage for yourself and/or dependents).

- Involuntary loss of other group coverage
- Acquisition of new dependent through marriage, birth, or adoption
- Change in Medicaid or CHIP eligibility

IRC Section 125 Status Change Events (Add, cancel, or change coverage for yourself and/or dependents).

- Involuntary loss or gain of other group coverage
- Divorce
- Death of covered spouse or child
- Change in employment status
- Medicare entitlement

If you think you have experienced a qualified family status change event, you will need to verify the event with Human Resources within 30 days of its occurrence. (60 days in the case of Medicaid or CHIP eligibility).

Using iNGAGED Mobile App

You can use the iNGAGED Mobile App to view your benefit plans and access important resources and documentation with ease.

iNGAGED makes accessing your health and benefits information easier than ever!

With iNGAGED, you can:

- View company benefit plans, resources, and documentation
- Quickly contact a benefit carrier using the “tap to call” feature in the app.
- Keep up to date with important company announcements via app push notifications.
- Store an image of your ID card in your app.
- Enrolled dependents are invited to access iNGAGED too.

Download the “**iNGAGED Benefits**” app from the Apple App Store or Google Play Store now!

Use the company code **COPP** to log in.

Insurance Glossary

Here is a list of relevant insurance-related terms to help you navigate the information provided in this guide.

Healthcare Provider: A healthcare provider is a person or company that provides a healthcare service to you, such as a dentist, primary care physician, chiropractor, clinical social worker, etc.

In-Network: Doctors, clinics, hospitals, and other providers are considered in network when they have made an agreement to care for the health plan's members. Health plans cover a greater share of the cost for using in-network healthcare providers than for providers who are out of network.

Out-of-Network: A health plan will cover treatment for doctors, clinics, hospitals, and other providers who are out of network, but covered employees will pay more out of pocket to use out-of-network providers than for in-network providers. Employees are also responsible for any difference between what the provider charges and the insurance company pays.

Preventive Care Services: Covered services intended to prevent disease or to identify disease while it is more easily treatable. Examples of preventive care services include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Your policy specifies what qualifies as preventive coverage at a 100% level.

Copay: A copay is a fixed-dollar amount that a plan member pays to a participating network doctor, caregiver, or other medical provider or pharmacy each time healthcare services are received.

Coinsurance: The portion of an eligible medical bill a plan member must pay. Coinsurance amounts are usually a percentage of the total eligible medical bill, such as 10%. Coinsurance applies after the member meets a required deductible or copay amount. Coinsurance is part of certain healthcare plans.

Deductible: A fixed-dollar amount that a plan member must pay for certain eligible services before the insurer begins applying insurance benefits.

Out-of-Pocket Maximum: The highest dollar amount you will need to pay during your benefit period for covered medical services from network providers. If you reach the out-of-pocket maximum, the insurance carrier will cover all additional in-network services at 100% until January 1 of the following year.

IMPORTANT

This information is not accounting, tax, or legal advice—please contact your accounting, tax, or legal professional for such guidance. This information should not be relied upon as advice regarding any individual situation.

It is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

This section will review the following health plans:

- **Medical**
- **Dental**
- **Vision**

Medical Plans

The City of Pembroke Pines offers two **UMR** medical plans.

Here is a closer look at how **UMR's** medical plan options work. You will find more plan highlights on the following page.

PROVIDER SEARCH: You can search for participating health care providers by visiting https://www.uhc.com/find-a-doctor and clicking "Search as a guest." Choose "Medical Directory" as your type of provider, then "Employed and Individual Plans". Select "Choice Plus" as you network and then enter your search criteria.

Below are highlights of the plans. Contact Human Resources for your payroll cost.

Your preferred lab facilities are **LabCorp** and **Quest Diagnostics –** you can save money when you use either of these facilities. They offer a wide variety of testing services, ranging from routine blood tests to complex gene-based, cardiology and molecular testing.

Quest Diagnostics	LabCorp

• Review your test results, whenever and wherever, using the MyQuest™ by Care360 patient portal and mobile health app.
• Automated Appointment Scheduling
  ○ Visit www.questdiagnostics.com and click "Make an Appointment" for easy scheduling
• Mobile App
  ○ Review your lab results from your smartphone, tablet or desktop
  ○ Access and share medical info and medications
• Convenient Locations
• Saturday Hours
	• LabCorp Patient™ portal allows you to view, download and print your LabCorp test results, and provides tools to pay your bill online
	• Online Appointment Scheduling
	  ○ Visit www.labcorp.com, enter your zip code, select a service, and click "Go" for easy scheduling
	• Convenient Locations
	• Saturday Hours

Medical Plans

COVERAGE	Plan 1 *Similar to an EPO Plan*		Plan 2 *Similar to a PPO Plan*	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible				
Individual	None	$10,000 per member	$300	$600
Family			$600	$1,000
Member Coinsurance				
	0%	50% after DED	10% after DED	30% after DED
Calendar Year Out-of-Pocket Maximum				
Individual	$6,350	Unlimited	$6,350	$6,350
Family	$12,700		$12,700	$12,700
Physician Visit				
Preventive Care	Covered in Full	50% after DED	Covered in Full	30% after DED
Primary Care Physician (PCP)	$15 copay	50% after DED	10% after DED	30% after DED
Specialist	$20 copay	50% after DED	10% after DED	30% after DED
Lab Work and Diagnostic Imaging				
Preventive	Covered in Full	50% after DED	Covered in Full	30% after DED
Diagnostic	PCP office: $15 copay Outpatient Setting: $25 copay	50% after DED	10% after DED	30% after DED
Hospital Services				
Inpatient Hospital	$150 copay per admission	50% after DED	10% after DED	30% after DED
Outpatient Surgery	Facility: $25 copay Surgeon: $100 copay	50% after DED	10% after DED	30% after DED
Emergency Medical Care				
Urgent Care	$50 copay	50% after DED	$50 copay	30% after DED
Emergency Room (waived if admitted)	$100 copay (for true emergencies only)		$100 copay (for true emergencies only)	
Prescription Drugs *OptumRX* Retail (34-day supply)				
Preferred Generic	$10 copay	Not covered	$10 copay	Not covered
Preferred Brand Name	$25 copay	Not covered	$25 copay	Not covered
Non-Preferred	$35 copay	Not covered	$35 copay	Not covered
Mail Order (90-day supply)	2x Retail copay	Not covered	2x Retail copay	Not covered
Contraceptives *Formulary List*	Covered in Full	Not covered	Covered in Full	Not covered

1) Usual & Customary (U&C) charges apply. For out-of-network services, the plan determines the reasonable charge for comparable services, treatments, or materials in a geographical area. The Plan will pay 50% for Plan 1 and 70% for Plan 2 of the U&C charges for out-of-network services. The member may be subject to the additional charges.

Teladoc Telemedicine

Teladoc® is a convenient and affordable option for a variety of medical services. Access quality healthcare from the comfort of home, during your lunch break or while traveling. You can even get a prescription sent to your local pharmacy, when medically necessary. Talk to a doctor anytime, anywhere by calling 1-800-Teladoc (1-800-835-2362) or visiting www.teladoc.com.

General Medicine: $5 copay per visit

Board-certified doctors are available 24/7/365 by web, phone, or app to treat flu, allergies, sinus infection, rash, sore throat and more.

Dermatology: $10 copay per visit

Log into your account to upload images of your skin issues and receive a response through Teladoc secure online message center within two business days. Treat on-going or complex issues like psoriasis, eczema, acne and more.

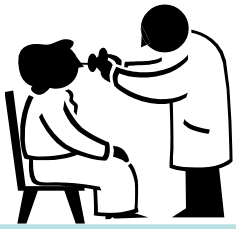
Behavioral Health: $5 copay per session

Schedule a video or phone appointment, seven days a week for support with anxiety, eating disorders, depression, family issues and more.

How to Register

1. **Set up your account:** Visit the website and click "Set up account". Follow the online instructions to provide the necessary information and to complete your medical history. When setting up your account online, you will be asked for a username. Your username can be found on your Teladoc membership card. If you do not have a membership card or know your username, simply select "No" and complete the information requested.
2. **Set up minor dependents (17 or younger):** Log into your account and click "My Family" from the top menu. Follow the online instructions to provide the necessary information and complete your dependent medical history.
3. **Set up adult dependents (18 or older):** Adult dependents set up their own account by visiting the website and clicking "Set up account". They should follow the online instructions to provide the necessary information and to complete their medical history.
4. **Request a Consult:** Once your account is set up, request a consult anytime and anywhere you need care. With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Express Clinics / Urgent Care / ER



Express Clinics

- Available at pharmacy
- When doctor is not available
- **Examples:** Common cold
- $5 copay

Urgent Care

- Immediate attention for **non-threatening** situation
- **Examples:** Ear infection, sprains, fever
- $50 copay

Emergency Room

- **For life-threatening injuries or illnesses ONLY**
- **Examples:** Chest pain, shortness of breath, uncontrollable bleeding, poisoning, serious burns, seizures, paralysis, broken bones
- $100 copay

UHealth Clinic
UNIVERSITY OF MIAMI HEALTH SYSTEM at Walgreens

minute clinic

Please note that many claim issues have arisen from visits to the facility mentioned below:

MEMORIAL 24/7 CARE CENTER LOCATED ON DOUGLAS ROAD

Please be aware, that per Memorial Hospital's website, Memorial Pembroke 24/7 Care Center (located on Douglas Rd) classifies the facility as an Emergency Department. Based on their self-classification, this location is considered an Emergency Department, not an Urgent Care Center. This means any charges by this facility are coded as an ER and not an urgent care facility. Due to the classification, for the charges to be processed as in-network eligible expenses, the visit must be a result of a "true emergency" as defined in the City's Health Plan. If the visit is not a direct result of a "true emergency", benefits will not be payable under the terms of the Plan and 100% of the expenses will be the responsibility of the Plan Participant (employee/eligible dependent).

Emergency Room

Emergency visits are covered for **TRUE Emergencies ONLY.**

What is a TRUE Emergency?

A condition that may cause loss of life or permanent or severe disability if not treated immediately.

TRUE Emergency

- $100 Copay per Visit
- Copay may be waived if admitted

NON-TRUE Emergency

- Not Covered

Additional Ways to Save

Health care and pharmacy costs continue to increase. Here are tips for staying on budget.

Look into discount drug programs offered by local pharmacies

Pharmacy	Program
★ **CanaRx – New Program!**	Check to see if a medication is offered – call 1-866-893-6337 or to view the complete formulary – enroll online or download an enrollment form – visit www.canarx.com | WebID: PPINES
GoodRx	Cut Medication Costs Through Comparison Shopping. Use GoodRx Coupons or Rx Savings Card at Local Pharmacies | www.GoodRx.com

Research brand name drug rebates online

Website	Offer
www.needymeds.org	Find help with the cost of medicine
www.gskforyou.com	Help with GSK medications and vaccines for qualified patients
www.rxpharmacycoupons.com	Search for drug coupons to use at your local pharmacy
www.internetdrugcoupons.com	Hundreds of free manufacturer drug coupons

Use freestanding Surgical and Diagnostic Centers when possible

Ambulatory Services	Save on a covered surgery by having it done at an in-network, non-hospital-affiliated ambulatory surgical center.
Freestanding Diagnostic Centers	Save on MRIs, CAT scans, X-rays, etc. by having them done at participating freestanding diagnostic centers.

Save time and money when you choose the right level of care

$	$$	$$$
Convenience Clinic	**Urgent Care**	**Emergency Room**
Use for preventive care services and common colds when your doctor is not available. This is a low-cost option	Use for immediate attention for non-threatening situations. Getting care will cost less than the ER and is generally quicker.	Use for life-threatening injuries, as ERs are best suited for medical emergencies. ER follow-ups are not covered so it is best to schedule with your PCP for a follow-up visit.

Pharmacy Benefits

Step Therapy

Our medical plans include "**Step Therapy**", which encourages medical providers to utilize prescriptions in a "step" process, which typically will result in participants having lower copayments. Additionally, UMR has a customary generic program. This means unless your provider indicates on the prescription to "dispense as written – "**DAW**" – a generic pharmaceutical will be dispensed when a generic alternative is available. If you or a covered participating dependent request a "brand name" when the prescribing medical provider does not indicate "DAW", you will be required to pay the applicable co-payment, plus the cost difference between the generic and the brand name prescription.

As a reminder, generic drugs can save you up to 60% on your total prescription costs. Once a brand name patent expires, less expensive generics become available. The FDA requires that generic drugs meet the same rigorous standards that all brand-name drugs do. Generic drugs are biologically equal to a brand-name drug in terms of dosage, safety, strength, quality performance characteristics, the way it's taken and should be used.

Prior Authorization

There are some medications that must be authorized by a doctor before you can get them, because the medications are approved or effective only for certain conditions.

Getting a short-term supply

If you must take a medication that requires prior authorization right away, there are two options that may work for you. First, ask your doctor if a sample is available. Or check with your pharmacy to request a short-term supply of 5 days or less. Keep in mind, you will be responsible for the full cost at that time. If the prior authorization request is approved, then your pharmacist can fill the rest of your prescription.

Requesting prior authorization

You, your pharmacist, or your doctor can start the prior authorization process by contacting OptumRx. They will work with your doctor to get the information needed for the review. Once they receive a completed prior authorization form from your doctor, they will conduct a review within a few days and send you and your doctor a letter regarding the decision.

CanaRx

CanaRx helps to keep more money in members' pockets. There are no copays, shipping charges or out-of-pocket costs to sign up. The program is FREE to members.

Examples of Savings:

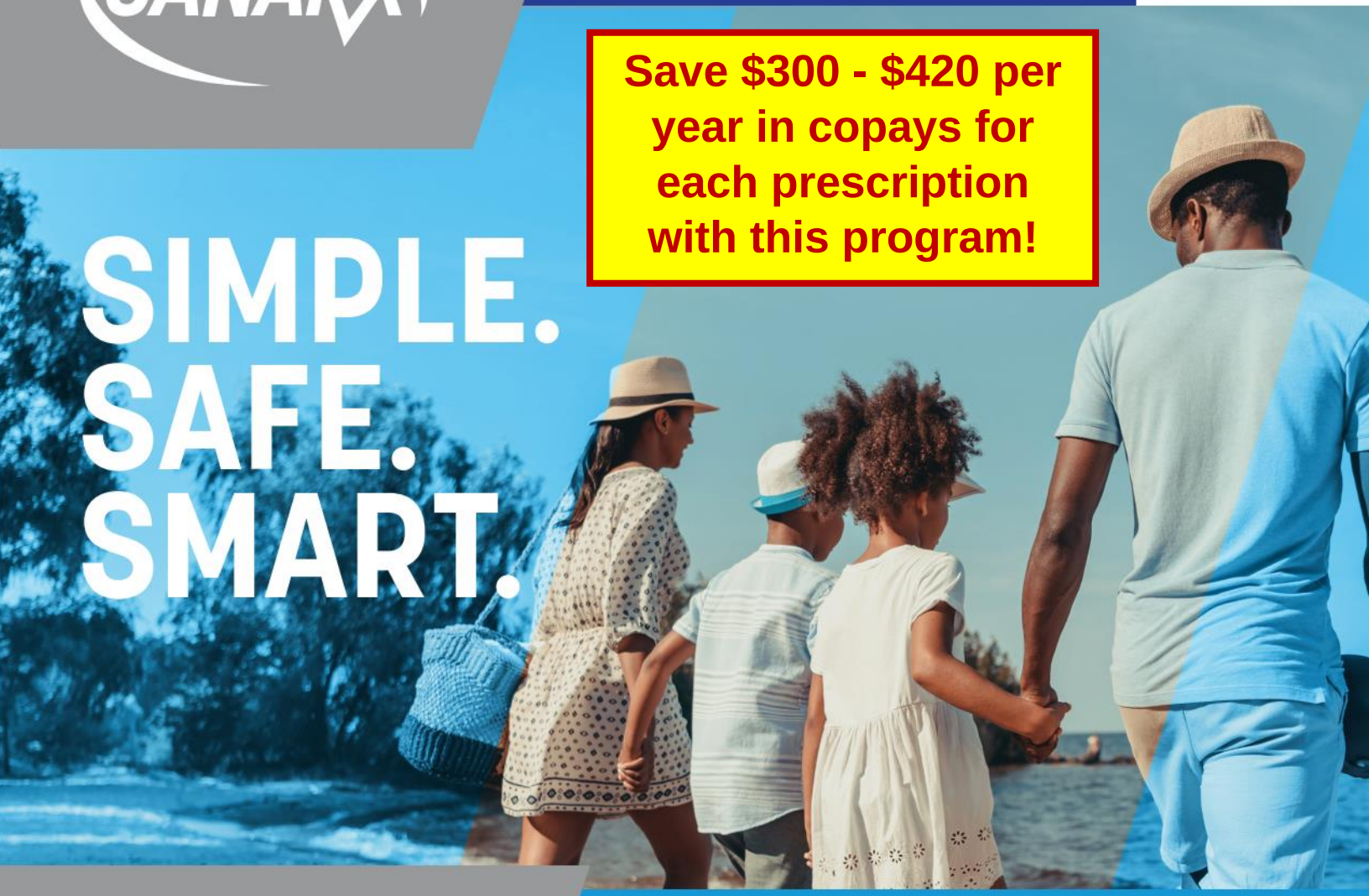
If you regularly take a brand-name medication, instead of paying $25/month ($300 annually), you will pay nothing, as long as your medication is on the CanaRx formulary.

If you take a non-preferred brand name medication regularly, instead of paying $35/month ($420 annually), you will pay nothing, as long as your medication is on the CanaRx formulary.

CANARX

City of Pembroke Pines

Save $300 - $420 per year in copays for each prescription with this program!



SIMPLE. SAFE. SMART.

SIGN UP TODAY

Medications FREE to your door!

CANARX is a voluntary international mail order prescription program that is available to eligible members and their dependents of the City of Pembroke Pines.

Brand name medications, in the original factory-sealed manufacturers packaging, are delivered DIRECT TO YOUR DOOR from certified pharmacies in Canada, the United Kingdom and Australia. YOU PAY NOTHING thanks to the savings CANARX brings to your plan.

- $0 Copay
- 450+ FREE Brand Name Medications
- Easy, convenient refills
- Refills only, no "new to you" meds
- No additional costs

Getting started is super easy!

1. Check to see if a medication is offered - call CANARX at **1-866-893-6337** or to view the complete formulary - and enroll online or download an enrollment form - visit **www.canarx.com** (WebID: **PPINES**).
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit documentation (completed enrollment form, prescription and a copy of your photo ID).
4. Sit back and relax...medication will be mailed direct to your home within 4 weeks!

For More Information

1-866-893-6337
www.canarx.com
WebID: PPINES

CANARX
Simple. Safe. Smart.

canarx.com | 1-866-893-6337

- ✓ $0 Copay
- ✓ FREE Brand-Name Medications
- ✓ FREE Delivery
- ✓ Worry-Free Refills

GET THESE POPULAR BRAND-NAME MEDICATIONS FOR FREE:

DOVATO	JANUVIA	RINVOQ
ELIQUIS	JARDIANCE	TASIGNA
FARXIGA	OTEZLA	XARELTO

Visit canarx.com or scan the QR code to see if your medication is offered.

Your WebID Is:

PPINES

ENROLL ONLINE TODAY!

- CANARX is available to eligible members and dependents covered through the health plan
- This voluntary program is available at NO COST
- Medications are shipped in the original factory-sealed manufacturers packaging from certified pharmacies in Canada, the United Kingdom and Australia
- FREE delivery direct to your mailbox

For more information, contact CANARX or your HR/Benefits Dept.

GoodRx

GoodRx

Save Up to 80% on Prescription Drugs Using GoodRx

Helps to Cut Medication Costs Through Comparison Shopping

- ✓ **No Fees**
- ✓ **No Obligation**
- ✓ **No Registration**

How it works:

- ✓ Download the GoodRx app
- ✓ Type the name of your prescription into the GoodRx site or mobile app and click "Find the Lowest Price"
- ✓ Select your savings coupon at your preferred pharmacy
- ✓ Show your coupon to the pharmacist to receive the discounted price
- ✓ Coupons are recommended for greater savings, but a request can also be submitted for a free GoodRx Pharmacy Discount Card.

GoodRx Prescription Drug Savings Card

Save up to 80% on prescription drugs at virtually every U.S. pharmacy!

BIN	003650
PCN	64
GROUP	GRXT1117

MEMBER ID
P23089

Customer Questions Call: 1-844-595-5222
Pharmacist Questions Call: 1-877-459-8474

Check goodrx.com to find the lowest prices on all FDA-approved drugs.

Ready to try GoodRx? Go to goodrx.com

Download the GoodRx App Now!

Download on the App Store | GET IT ON Google Play

Dental Plans

The City of Pembroke Pines offers a DHMO plan and two PPO plans through **Delta Dental**. Below are highlights of the plans and your monthly payroll contributions.

PROVIDER SEARCH: You can search for providers by visiting www.deltadental.com, clicking "Find a Dentist" in the top right of the page and entering your search criteria according to your plan type.

DHMO Plan: The DHMO plan requires you to seek care exclusively from participating providers. However, you do need to select a primary care dentist. Services are paid through copayments. The plan provides you with an unlimited benefit maximum. Refer to the Benefits Summary for a full list of covered procedures.

You must select a primary care dentist if you elect the DHMO. You may make this assignment via the website or by calling Delta Dental Customer Service. If you do not make the assignment, the first general dentist you visit may be assigned as your PCP once the dentist submits their qualifying claim. You will receive a letter informing you that the new provider is assigned.

Plan Highlights	DHMO Delta Care USA
Preventive Services	
Cleanings (Code D1110/D1120) 2 per Calendar Year	No charge
Routine X-Rays	No charge
Resin Based – Posterior One Surface (Code D2391)	$47 copay
Root Canal – Molar (Code D3330)	$335 copay, excludes final restoration
Orthodontics (Dependent Children to age 19)	
Start-Up (Code D8660/8999)	$80 / $400 copay
Comprehensive Treatment Child/Adult (Code D8080/D8090)	$1,530 / $1,730 copay
Retention (Code D8680)	$220 copay
Monthly Payroll Contributions	
Employee Only	$8.86
Employee + Spouse	$17.25
Employee + Child(ren)	$24.10

Dental Plans

PPO Plan: The PPO plans are designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind; you'll receive the highest level of benefit from the plan if you select an in-network contracted PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rates. A calendar year maximum benefit will apply to in and out-of-network services.

Our DPPO plans offer two networks, the PPO and the Premier. PPO and Premier dentists cannot charge you more than their agreed PPO or Premier fees. This helps lower your out-of-pocket costs.

Plan Highlights	DPPO 1250	
	In-Network	Out-of-Network[1]
Calendar Year Maximum Benefit	$1,250 per member	
Calendar Year Deductible (DED)		
Individual / Family	$50 / $150	$50 / $150
Type I: Diagnostic & Preventive	Member 0% Delta Dental 100%, DED Waived	
Type II: Basic Services	Member 20% Delta Dental 80%, after DED	
Type III: Major Services	Member 50% Delta Dental 50%, after DED	
Orthodontics (Dependent Children to age 19)		
Comprehensive	50%; $1,000 Lifetime Maximum	
Monthly Payroll Contributions		
Employee Only	$26.89	
Employee + One	$53.76	
Employee + Family	$94.59	

Plan Highlights	DPPO 5000	
	In-Network	Out-of-Network[1]
Calendar Year Maximum Benefit	$5,000 per member	
Calendar Year Deductible (DED)		
Individual / Family	$50 / $150	$50 / $150
Type I: Diagnostic & Preventive	Member 0% Delta Dental 100%, DED Waived	
Type II: Basic Services	Member 20% Delta Dental 80%, after DED	Member 40% Delta Dental 60%, after DED
Type III: Major Services	Member 50% Delta Dental 50%, after DED	Member 60% Delta Dental 40%, after DED
Orthodontics (Dependent Children to age 19)		
Comprehensive	50%; $1,000 Lifetime Maximum	
Monthly Payroll Contributions		
Employee Only	$44.15	
Employee + One	$88.27	
Employee + Family	$155.31	

1) Out-of-Network benefits are based on usual and customary changes

DELTA DENTAL

Resources at your fingertips

Go online to manage your plan

Whether you need to check your benefits or select a new dentist, you can do it all with Delta Dental's online tools.

Create an account

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- Download plan documents.
- Find an in-network dentist.
- View your member ID card or print a paper copy.
- Update your settings to paperless.

Try it out: Go to **deltadentalins.com** and choose **Log in** to create an account or log in to your existing account.

Tip: Access your benefits info on mobile, tablet or desktop!

Find an in-network dentist

What you can do:

- Search by distance, specialty, language spoken, extended office hours, wheelchair accessibility and more.
- Browse Yelp ratings and reviews from real patients, and check out DentaQual scores for an objective quality metric based on actual claims data.

Try it out: Go to **deltadentalins.com**, enter your address or ZIP code and select your network. Not sure which network to choose? Log in to your account first and follow the prompts to find a dentist.

deltadentalins.com/enrollees

Understand your plan

What you can do:

- Browse answers to frequently asked questions.
- Get tips on planning for a dental visit.
- Find claim forms.
- Learn how to go paperless, sign up for a virtual dental visit and coordinate coverage with two or more plans.

Try it out: Visit **deltadentalins.com/enrollees** for useful resources and tips.

Explore dental wellness

What you can do:

- Browse articles on everything from acid reflux to xylitol.
- Find delicious recipes for healthy meals.
- Check out videos on preventive care and common procedures.

Try it out: Visit **deltadentalins.com/wellness** to start learning.

Download the app

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- View your member ID card.
- Get a cost estimate.
- Find an in-network dentist.

Try it out: Search for Delta Dental in the App Store or Google Play.

Tip: Don't need another app? Just visit **deltadentalins.com** on your smartphone or tablet and log in to your account.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

EF30 #134298I (rev. 04/22)

DELTA DENTAL®

Keep smiling

DeltaCare® USA

Dental benefits made easy!

When you enroll in a DeltaCare USA[1] plan, you'll choose a primary care dentist from our network of carefully screened, private-practice dentists. You must visit your primary care dentist to receive benefits.[2]

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums[3] for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

Delta Dental Insurance Company provides benefits as a Prepaid Limited Health Services Organization as described in Chapter 636 of the Florida Statutes.

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

[1] DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. Delta Dental is a registered trademark of Delta Dental Plans Association.

[2] Verify your selected DeltaCare USA primary care dentist before each appointment.

[3] Plans with an Accidental Injury Rider have a $1,600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

deltadentalins.com/enrollees

Frequently asked questions

What you need to know about your DeltaCare® USA plan

Getting started

1. **How do I enroll in a DeltaCare USA plan?**
   Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. **How do I get started using my DeltaCare USA plan?**
   Once we process your enrollment, we'll mail you welcome materials that will include:

   - **The name, address and phone number of your selected primary care dentist.** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
   - **Your Evidence/Certificate of Coverage (plan booklet).** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
   - **An ID card.** This card is for your records only — you do not need to present it in order to receive treatment.

3. **How long will it take to get an appointment with my primary care dentist?**
   Two to four weeks[1] is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time slot, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. **How much will my dental treatments cost? How do I pay?**
   With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact Customer Service. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

Choosing a dentist

5. **How do I select my primary care dentist?**
   When you enroll, you must select a primary care dentist from the DeltaCare USA network[2]. To search for a dentist, use the **Find a dentist** tool at **deltadentalins.com** and select the DeltaCare USA network. You must visit your selected primary care dentist to use plan benefits. Important: Dental services provided by a dentist other than your selected primary care dentist will be denied. Your primary care dentist will refer you to a specialist if any specialty care is required.

6. **Does everyone in my family have to choose the same primary care dentist?**
   No. Each family member can select his or her own primary care network dentist.[3]

7. **Can I change my primary care dentist?**
   Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your online account or contact Customer Service. Selections made by the 15th of the month are effective immediately. Selections made on or after the 16th of the month will be effective on the first day of the following month.

[1] In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[2] In AZ, MD, and TX, if you do not select a dentist when you enroll, we will choose one for you.
[3] In MA, you cannot select more than three primary care dentist facilities per family.

8. **My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?**
No. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists. You must visit your selected primary care network dentist to receive benefits under this plan.

9. **What should I do if I need to see a specialist?**
If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

General plan information

10. **If I'm traveling, is emergency treatment covered under my plan?**
You and your eligible dependents have out-of-area coverage for dental emergencies.[3] Your out-of-area emergency benefit (typically limited to $100 per person) is for services to relieve pain until you can return to your primary care network dentist.[4] Standard plan limitations, exclusions and copayments may apply.

11. **Can I access my plan online?**
Yes. Visit **deltadentalins.com** to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your primary care dentist and more.

12. **Does my plan cover pre-existing conditions? What about treatments that are in progress?**
Treatment for pre-existing conditions (except work in progress[5]), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

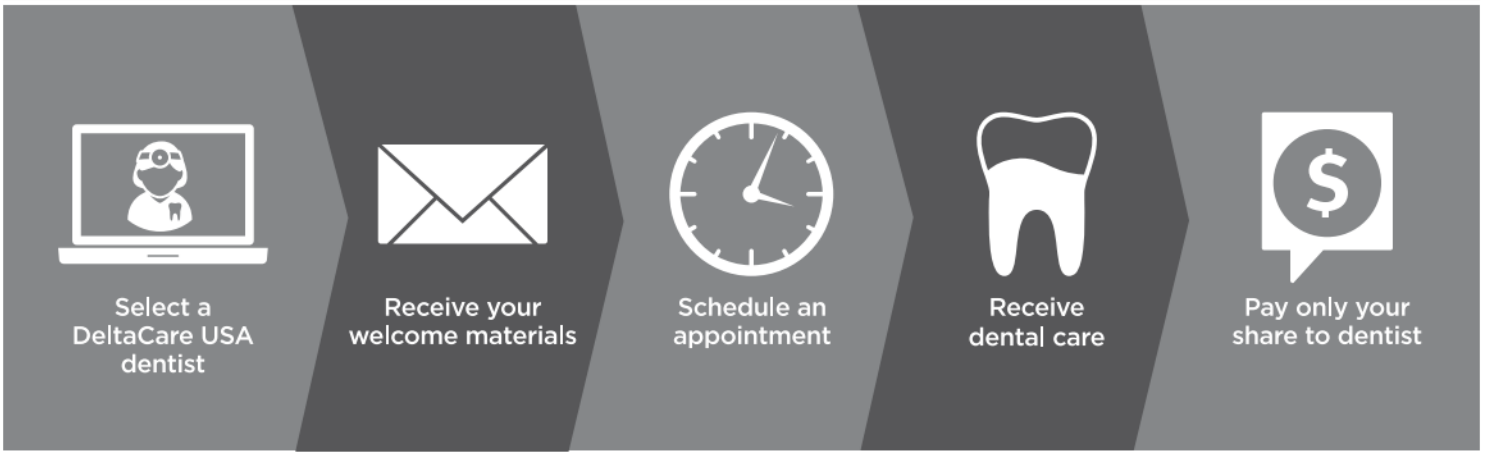
13. **Does my plan cover teeth whitening?**
Yes. External bleaching is a benefit under your DeltaCare USA plan. Review your plan booklet for more information and talk to your dentist about your options.

14. **Does my plan cover tooth-colored fillings and crowns?**
Yes. Porcelain and other tooth-colored materials are included in this plan.

15. **What if I have additional questions about my plan?**
Please contact us for additional support. Our Customer Service representatives can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

[3] State-specific minimum distance requirements may apply.
[4] In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[5] In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

We make it easy for you!



FAQ_DCU_USA_STD #135998-10 (rev. 01/23)

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **You should discuss all treatment options with Your Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2023 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	COPAYMENTS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	$33.00
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 series every 36 months, or more frequently if medically necessary*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 2 series every 12 months, or more frequently if medically necessary*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image - *limited to 1 every 36 months, or more frequently if medically necessary*	No Cost
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	$110.00
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	$110.00
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	$110.00
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	$150.00
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures - *limited to 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation*	$145.00
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$25.00
D0460	Pulp vitality tests	$14.00
D0470	Diagnostic casts	No Cost

D0472	Accession of tissue, gross examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *2 D1110, D1120 or D4346 per calendar year, or more frequently if medically necessary*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the calendar year)*	$45.00
D1120	Prophylaxis *cleaning* - child - *2 D1110, D1120 or D4346 per calendar year, or more frequently if medically necessary*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the calendar year)*	$30.00
D1206	Topical application of fluoride varnish - *2 D1206 or D1208 per calendar year, or more frequently if medically necessary*	No Cost
D1206	*Additional topical application of fluoride varnish - (within the calendar year)*	$15.00
D1208	Topical application of fluoride - excluding varnish - *2 D1206 or D1208 per calendar year, or more frequently if medically necessary*	No Cost
D1208	*Additional topical application of fluoride - excluding varnish (within the calendar year)*	$15.00
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth	$12.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$12.00
D1353	Sealant repair - per tooth	$12.00
D1354	Application of caries arresting medicament - per tooth - *2 per 12 month period, or more frequently if medically necessary*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$110.00
D1516	Space maintainer - fixed - bilateral, maxillary	$170.00
D1517	Space maintainer - fixed - bilateral, mandibular	$170.00
D1520	Space maintainer - removable - unilateral - per quadrant	$120.00
D1526	Space maintainer - removable - bilateral, maxillary	$180.00
D1527	Space maintainer - removable - bilateral, mandibular	$180.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	$110.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns, pontics and/or bridge retainers in the same treatment plan, an Enrollee may be charged an additional $135.00 per unit, beyond the 6th covered unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.
** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $150.00 in addition to the listed Copayment. Refer to Limitations and Exclusions of Benefits for additional information.*

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$88.00
D2390	Resin-based composite crown, anterior	$88.00
D2391	Resin-based composite - one surface, posterior	$47.00
D2392	Resin-based composite - two surfaces, posterior	$59.00
D2393	Resin-based composite - three surfaces, posterior	$82.00
D2394	Resin-based composite - four or more surfaces, posterior	$115.00
D2510	Inlay - metallic - one surface	$240.00
D2520	Inlay - metallic - two surfaces	$290.00
D2530	Inlay - metallic - three or more surfaces	$340.00
D2542	Onlay - metallic - two surfaces	$470.00
D2543	Onlay - metallic - three surfaces	$470.00
D2544	Onlay - metallic - four or more surfaces	$470.00
D2610	Inlay - porcelain/ceramic - one surface	$325.00
D2620	Inlay - porcelain/ceramic - two surfaces	$350.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$395.00
D2642	Onlay - porcelain/ceramic - two surfaces	$445.00
D2643	Onlay - porcelain/ceramic - three surfaces	$480.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$500.00
D2650	Inlay - resin-based composite - one surface	$205.00
D2651	Inlay - resin-based composite - two surfaces	$240.00
D2652	Inlay - resin-based composite - three or more surfaces	$260.00
D2662	Onlay - resin-based composite - two surfaces	$370.00
D2663	Onlay - resin-based composite - three surfaces	$395.00
D2664	Onlay - resin-based composite - four or more surfaces	$440.00
D2710	Crown - resin-based composite (indirect)	$290.00
D2712	Crown - 3/4 resin-based composite (indirect)	$290.00
D2720	Crown - resin with high noble metal	$440.00
D2721	Crown - resin with predominantly base metal	$340.00
D2722	Crown - resin with noble metal	$380.00
D2740	Crown - porcelain/ceramic	$490.00
D2750	Crown - porcelain fused to high noble metal	$450.00
D2751	Crown - porcelain fused to predominantly base metal	$400.00
D2752	Crown - porcelain fused to noble metal	$425.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$450.00
D2780	Crown - 3/4 cast high noble metal	$460.00
D2781	Crown - 3/4 cast predominantly base metal	$400.00
D2782	Crown - 3/4 cast noble metal	$435.00
D2783	Crown - 3/4 porcelain/ceramic	$460.00
D2790	Crown - full cast high noble metal	$460.00
D2791	Crown - full cast predominantly base metal	$410.00
D2792	Crown - full cast noble metal	$435.00

D2794	Crown - titanium and titanium alloys	$460.00
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression	$95.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$43.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$43.00
D2920	Re-cement or re-bond crown	$43.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$88.00
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$105.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$165.00
D2930	Prefabricated stainless steel crown - primary tooth	$105.00
D2931	Prefabricated stainless steel crown - permanent tooth	$105.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$135.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$165.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$165.00
D2940	Protective restoration	$13.00
D2941	Interim therapeutic restoration - primary dentition	$13.00
D2949	Restorative foundation for an indirect restoration	$92.00
D2950	Core buildup, including any pins when required	$125.00
D2951	Pin retention - per tooth, in addition to restoration	$13.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$165.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$110.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$135.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$80.00
D2960	Labial veneer (resin laminate) - direct - *limited to replacement of significant tooth structure loss due to caries or fracture*	$94.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	$83.00
D2980	Crown repair necessitated by restorative material failure	$40.00
D2981	Inlay repair necessitated by restorative material failure	$40.00
D2982	Onlay repair necessitated by restorative material failure	$40.00
D2983	Veneer repair necessitated by restorative material failure	$40.00
D2990	Resin infiltration of incipient smooth surface lesions	$12.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$14.00
D3120	Pulp cap - indirect (excluding final restoration)	$14.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$72.00
D3221	Pulpal debridement, primary and permanent teeth	$72.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$72.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$85.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$85.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$210.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$245.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$335.00
D3331	Treatment of root canal obstruction; non-surgical access	$97.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$97.00
D3333	Internal root repair of perforation defects	$97.00
D3346	Retreatment of previous root canal therapy - anterior	$300.00
D3347	Retreatment of previous root canal therapy - premolar	$345.00
D3348	Retreatment of previous root canal therapy - molar	$430.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$97.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$77.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$77.00
D3410	Apicoectomy - anterior	$275.00
D3421	Apicoectomy - premolar (first root)	$305.00

D3425	Apicoectomy - molar (first root)	$340.00
D3426	Apicoectomy (each additional root)	$110.00
D3430	Retrograde filling - per root	$72.00
D3450	Root amputation - per root	$95.00
D3471	Surgical repair of root resorption - anterior	$225.00
D3472	Surgical repair of root resorption - premolar	$225.00
D3473	Surgical repair of root resorption - molar	$225.00
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$225.00
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$225.00
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$225.00
D3920	Hemisection (including any root removal), not including root canal therapy	$85.00
D3921	Decoronation or submergence of an erupted tooth	$12.00

D4000-D4999 V. PERIODONTICS

- *Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*
- *Periodontal regenerative procedures, D4263 D4264, D4266 and D4267, are limited to 1 per site (or per tooth, if applicable).*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$180.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$91.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$91.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$235.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$125.00
D4245	Apically positioned flap	$235.00
D4249	Clinical crown lengthening - hard tissue	$255.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$400.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$280.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$225.00
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	$305.00
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	$283.00
D4270	Pedicle soft tissue graft procedure	$300.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$650.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$225.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$310.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$310.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$155.00
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	$410.00
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	$155.00
D4286	Removal of non-resorbable barrier	$0.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$83.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$42.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *2 D1110, D1120 or D4346 per calendar year, or more frequently if medically necessary*	No Cost

D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	$65.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - *for each of the first two teeth treated within a quadrant following root planing or periodontal maintenance*	$45.00
D4910	Periodontal maintenance - *following active periodontal therapy, limited to 4 treatments per calendar year*	$53.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes other delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$625.00
D5120	Complete denture - mandibular	$625.00
D5130	Immediate denture - maxillary	$680.00
D5140	Immediate denture - mandibular	$680.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$525.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$525.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$715.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$715.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$525.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$525.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$715.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$715.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery .	$605.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) .	$605.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$525.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$525.00
D5410	Adjust complete denture - maxillary	$43.00
D5411	Adjust complete denture - mandibular	$43.00
D5421	Adjust partial denture - maxillary	$46.00
D5422	Adjust partial denture - mandibular	$46.00
D5511	Repair broken complete denture base, mandibular	$88.00
D5512	Repair broken complete denture base, maxillary	$88.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$76.00
D5611	Repair resin partial denture base, mandibular	$88.00
D5612	Repair resin partial denture base, maxillary	$88.00
D5621	Repair cast partial framework, mandibular	$88.00
D5622	Repair cast partial framework, maxillary	$88.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$110.00
D5640	Replace broken teeth - per tooth	$81.00
D5650	Add tooth to existing partial denture	$88.00
D5660	Add clasp to existing partial denture - per tooth	$110.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$190.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$190.00
D5710	Rebase complete maxillary denture	$250.00

D5711	Rebase complete mandibular denture	$250.00
D5720	Rebase maxillary partial denture	$250.00
D5721	Rebase mandibular partial denture	$250.00
D5725	Rebase hybrid prosthesis	$250.00
D5730	Reline complete maxillary denture (chairside)	$145.00
D5731	Reline complete mandibular denture (chairside)	$145.00
D5740	Reline maxillary partial denture (chairside)	$145.00
D5741	Reline mandibular partial denture (chairside)	$145.00
D5750	Reline complete maxillary denture (laboratory)	$210.00
D5751	Reline complete mandibular denture (laboratory)	$210.00
D5760	Reline maxillary partial denture (laboratory)	$210.00
D5761	Reline mandibular partial denture (laboratory)	$210.00
D5765	Soft liner for complete or partial removable denture - indirect	$210.00
D5810	Interim complete denture (maxillary)	$315.00
D5811	Interim complete denture (mandibular)	$315.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	$280.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	$280.00
D5850	Tissue conditioning, maxillary	$40.00
D5851	Tissue conditioning, mandibular	$40.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES

- The following are limited to no more than two (2) each per calendar year: Implants, Implant supported prosthetics and Implant abutments.

- Replacement of crowns, bridges and implant supported dentures requires the existing restoration to be 5+ years old.

** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $150.00 in addition to the listed Copayment. Refer to Limitations and Exclusions of Benefits for additional information.*

D6010	Surgical placement of implant body: endosteal implant	$1,005.00
D6011	Surgical access to an implant body (second stage implant surgery)	$145.00
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$390.00
D6013	Surgical placement of mini implant	$340.00
D6040	Surgical placement: eposteal implant	$940.00
D6050	Surgical placement: transosteal implant	$920.00
D6055	Connecting bar - implant supported or abutment supported	$345.00
D6056	Prefabricated abutment - includes modification and placement	$330.00
D6057	Custom fabricated abutment - includes placement	$425.00
D6058	Abutment supported porcelain/ceramic crown	$740.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$750.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$610.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$710.00
D6062	Abutment supported cast metal crown (high noble metal)	$720.00
D6063	Abutment supported cast metal crown (predominantly base metal)	$545.00
D6064	Abutment supported cast metal crown (noble metal)	$690.00
D6065	Implant supported porcelain/ceramic crown	$780.00
D6066	Implant supported crown - porcelain fused to high noble alloys	$750.00
D6067	Implant supported crown - high noble alloys	$730.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	$725.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$750.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$485.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$660.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$750.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$415.00
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$425.00
D6075	Implant supported retainer for ceramic FPD	$780.00

D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$750.00
D6077	Implant supported retainer for metal FPD - high noble alloys	$750.00
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments - *limited to 1 per calendar year*	$65.00
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure - *limited to 1 per 24 months*	$65.00
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$610.00
D6083	Implant supported crown - porcelain fused to noble alloys (noble metal)	$710.00
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$655.00
D6086	Implant supported crown - predominantly base alloys (predominantly base metal)	$545.00
D6087	Implant supported crown - noble alloys	$690.00
D6088	Implant supported crown - titanium and titanium alloys	$655.00
D6090	Repair implant supported prosthesis, by report - *limited to 1 per calendar year*	$130.00
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment - *limited to 1 per calendar year*	$60.00
D6092	Re-cement or re-bond implant/abutment supported crown	$72.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$95.00
D6094	Abutment supported crown - titanium and titanium alloys	$655.00
D6095	Repair implant abutment, by report - *limited to 1 per calendar year*	$130.00
D6096	Remove broken implant retaining screw - *limited to 1 per calendar year*	$50.00
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$655.00
D6098	Implant supported retainer - porcelain fused to predominantly base alloys (predominantly base metal)	$485.00
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys (noble metal)	$660.00
D6100	Surgical removal of implant body - *limited to 1 per calendar year*	$245.00
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure - *limited to 1 per calendar year*	$125.00
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure - *limited to 1 per calendar year*	$240.00
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure - *limited to 1 per calendar year*	$290.00
D6104	Bone graft at time of implant placement - *limited to 1 per calendar year*	$290.00
D6105	Removal of implant body not requiring bone removal or flap elevation - *limited to 1 per calendar year*	$12.00
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$925.00
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$925.00
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$1,015.00
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$1,015.00
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$925.00
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$925.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$1,015.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$1,015.00
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys (predominantly base metal)	$415.00
D6121	Implant supported retainer for metal FPD - predominantly base alloys (predominantly base metal)	$415.00
D6122	Implant supported retainer for metal FPD - noble alloys (noble metal)	$425.00
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$620.00
D6190	Radiographic/surgical implant index, by report - *limited to 1 per calendar year*	$165.00
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$620.00
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$750.00
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant - *limited to 1 in 24 months*	No Cost
D6198	Remove interim implant component	$0.00

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture (bridge))

- When there are more than six crowns, pontics and/or bridge retainers in the same treatment plan, an Enrollee may be charged an additional $135.00 per unit, beyond the 6th covered unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $150.00 in addition to the listed Copayment. Refer to Limitations and Exclusions of Benefits for additional information.*

D6210	Pontic - cast high noble metal	$450.00
D6211	Pontic - cast predominantly base metal	$410.00
D6212	Pontic - cast noble metal	$435.00
D6214	Pontic - titanium and titanium alloys	$460.00
D6240	Pontic - porcelain fused to high noble metal	$450.00
D6241	Pontic - porcelain fused to predominantly base metal	$410.00
D6242	Pontic - porcelain fused to noble metal	$435.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$435.00
D6245	Pontic - porcelain/ceramic	$455.00
D6250	Pontic - resin with high noble metal	$390.00
D6251	Pontic - resin with predominantly base metal	$350.00
D6252	Pontic - resin with noble metal	$375.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$395.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$460.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$425.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$460.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$350.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$400.00
D6606	Retainer inlay - cast noble metal, two surfaces	$415.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$425.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$460.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$470.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$440.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$460.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$325.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$400.00
D6614	Retainer onlay - cast noble metal, two surfaces	$350.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$435.00
D6624	Retainer inlay - titanium	$450.00
D6634	Retainer onlay - titanium	$450.00
D6720	Retainer crown - resin with high noble metal	$385.00
D6721	Retainer crown - resin with predominantly base metal	$335.00
D6722	Retainer crown - resin with noble metal	$360.00
D6740	Retainer crown - porcelain/ceramic	$500.00
D6750	Retainer crown - porcelain fused to high noble metal	$460.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$410.00
D6752	Retainer crown - porcelain fused to noble metal	$435.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$460.00
D6780	Retainer crown - 3/4 cast high noble metal	$460.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$410.00
D6782	Retainer crown - 3/4 cast noble metal	$435.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$460.00
D6784	Retainer crown - titanium and titanium alloys	$460.00
D6790	Retainer crown - full cast high noble metal	$460.00
D6791	Retainer crown - full cast predominantly base metal	$410.00
D6792	Retainer crown - full cast noble metal	$435.00
D6794	Retainer crown - titanium and titanium alloys	$460.00
D6930	Re-cement or re-bond fixed partial denture	$61.00

D6940	Stress breaker	$60.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$80.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- *Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.*

D7111	Extraction, coronal remnants - primary tooth	$12.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$12.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$53.00
D7220	Removal of impacted tooth - soft tissue	$46.00
D7230	Removal of impacted tooth - partially bony	$91.00
D7240	Removal of impacted tooth - completely bony	$115.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$125.00
D7250	Removal of residual tooth roots (cutting procedure)	$53.00
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$91.00
D7260	Oroantral fistula closure	$125.00
D7261	Primary closure of a sinus perforation	$125.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$14.00
D7280	Exposure of an unerupted tooth	$14.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$14.00
D7283	Placement of device to facilitate eruption of impacted tooth	$8.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$78.00
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$65.00
D7287	Exfoliative cytological sample collection	$20.00
D7288	Brush biopsy - transepithelial sample collection	$78.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$58.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$33.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$78.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$40.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$14.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$14.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$14.00
D7472	Removal of torus palatinus	$14.00
D7473	Removal of torus mandibularis	$14.00
D7485	Reduction of osseous tuberosity	$78.00
D7509	Marsupialization of odontogenic cyst	$14.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$14.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$20.00
D7880	Occlusal orthotic device, by report - *limited to 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment*	$330.00
D7881	Occlusal orthotic device adjustment	$43.00
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach - *limited to 1 per calendar year; only covered in conjunction with the surgical placement of implant*	$850.00
D7952	Sinus augmentation via a vertical approach - *limited to 1 per calendar year; only covered in conjunction with the surgical placement of implant*	$640.00
D7953	Bone replacement graft for ridge preservation - per site - *limited to 1 per lifetime; only covered in conjunction with the surgical placement of implant*	$100.00
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7963	Frenuloplasty	$20.00
D7970	Excision of hyperplastic tissue - per arch	$90.00
D7971	Excision of pericoronal gingiva	$90.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for orthodontic treatment covers up to 24 months of active treatment.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.
- Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee at the Orthodontist's submitted fee.

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$575.00
D0210	Intraoral - comprehensive series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	
D0470	Diagnostic casts	
D0801	3D dental surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	
	The benefit for post-treatment records includes:	$140.00
D0210	Intraoral - comprehensive series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$950.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$950.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$950.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$985.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,530.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,530.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,730.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$80.00
D8670	Periodic orthodontic treatment visit - *included in comprehensive case fee*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$220.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$400.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$84.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$84.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$73.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$73.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	$55.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost

D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9941	Fabrication of athletic mouthguard - *limited to 1 per 12 month period*	$110.00
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 per 24 months*	$205.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 per 24 months*	$205.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 per 24 months*	$205.00
D9951	Occlusal adjustment, limited	$40.00
D9952	Occlusal adjustment, complete	$210.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice*	$10.00
D9987	Canceled appointment - *without 24 hour notice*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialized Services, and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. If the You accept a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the You may be charged an additional $135.00 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).

4. When recommending covered crown(s), bridge pontic(s) and/or bridge retainers, which are supported either by a natural tooth or dental implant, Contract Dentists may offer services that utilize brand or trade names at an additional fee. You must be offered the Plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If You choose the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec) the Contract Dentist may charge an additional fee not to exceed $150.00 in addition to the listed Copayment. Contact the Customer Service department at 800-422-4234 if You have questions regarding the additional fee or name brand services.

5. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

6. Your cost for receiving orthodontic treatment when coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. You make payment directly to the Contract Orthodontist as arranged.

7. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees at the time of Your original effective date if You are in active treatment started under Your previous employer sponsored dental plan as long as You continue to be eligible under the DeltaCare USA Plan. Active treatment means tooth movement has begun. You are responsible for all Copayments and fees subject to the provisions of Your prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

8. Fabrication of athletic mouthguard is limited to once every 12 months.

9. If any existing fixed bridge or removable denture that already replaces the tooth or teeth, which would be replaced by a new implant-supported prosthesis, that existing appliance must be eligible for replacement under the terms of the Contract.

10. Replacement of implants and implant-supported prosthesis requires the existing implants and implant-supported prosthesis to be 5+ years old.

11. Implants and implant supported crowns and prosthesis are covered to replace one or more natural permanent teeth lost due to accidental trauma or removal.

12. Implant removal is limited to one (1) for each implant during Your lifetime.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that in the professional opinion of the Contract Dentist:

   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**

   b. is inconsistent with generally accepted standards for dentistry.

3. Services solely for:

   a. cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch); or

   b. conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

4. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and implant abutments, and fixed partial dentures (bridges) whether supported by a natural tooth or dental implant.

5. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

6. Procedures that may include:

   a. precious metal for removable appliances;

   b. metallic or permanent soft bases for complete dentures;

   c. porcelain denture teeth;

   d. precision abutments for removable partials or fixed partial dentures including but not limited to overlays and related specialized appliances; and/or

   e. personalization and characterization of complete and partial dentures.

7. Procedures that may include:

   a. pre-implant diagnostic and therapeutic services, which are solely done to facilitate the placement of a dental implant including cone beam CT capture and interpretation, bone grafts and/or sinus augmentation;

   b. post-implant maintenance, osseous surgeries and/or bone grafts; and/or

   c. removal of a dental implant and all other services associated with a dental implant, unless listed as a covered benefit.

8. Consultations for non-covered Benefits.

9. Dental services received from any dental facility other than the Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Evidence of Coverage.

10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

11. Prescription drugs.

12. Dental expenses incurred in connection with any dental or orthodontic procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

13. Lost, stolen or broken orthodontic appliances.

14. Changes in orthodontic treatment necessitated by accident of any kind.

15. Myofunctional and parafunctional appliances and/or therapies.

16. Composite or ceramic brackets, lingual adaptation of orthodontic bands.

17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

18. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

19. An implant-supported prosthesis with one abutment supported by a natural tooth and the second supported by an implant are not covered.

20. Implant and implant-supported crowns and appliances are not covered benefits for Enrollees under 19 years of age.

21. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment.

Useful information at your fingertips

Boost your wellness IQ

Find oral health resources, including articles, quizzes, videos and a subscription to *Grin!*, our free dental wellness e-magazine at **deltadentalins.com/wellness**.

Find a network dentist near you

Use our convenient **Find a dentist** tool and select DeltaCare USA as your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Sign up for an online account

Sign up for a free, secure online account.

- Review your plan benefits
- Access your ID card

Contact us

Need help? Let us know.

Online: Visit **deltadentalins.com/contact**

Write to:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234
Customer Service agents are available Monday through Friday, 8 am to 9 pm, Eastern time. Or, use our automated phone system, available 24/7.

Underwritten by:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Administered by:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

NOTE: This is only a brief summary of your plan.
This brochure is not intended to replace your legally required plan booklet. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the "Description of Benefits and Copayments" and "Limitations and Exclusions of Benefits" in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage, which will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at **800-422-4234**.

#135998-02 (rev. 1/23)

DELTA DENTAL

Delta Dental PPO™
Delta Dental Premier®

Get the Facts Straight

Find out about orthodontic benefits

Preparing for orthodontic treatment? Start by reviewing these FAQs about orthodontic benefits under most Delta Dental PPO and Delta Dental Premier plans. Then, log into your online account at **deltadentalins.com** to review your coverage.[1]

Choosing an orthodontist

1. **Can I select any orthodontist? How can I find one?**
   You can visit any licensed orthodontist under your plan, but you'll usually save the most if you choose a Delta Dental orthodontist.[1, 2] Search for a dentist at **deltadentalins.com** and enter "orthodontist" in the keyword field. You can also ask your general dentist to recommend an in-network orthodontist or call Customer Service for help.

Orthodontic coverage

2. **What's covered?**
   Coverage varies depending on your plan,[1] but most Delta Dental plans include:

   - Pre-orthodontic treatment visit
   - Exam and start-up records
   - X-rays
   - Orthodontist-recommended tooth extractions
   - Comprehensive orthodontic treatment
   - Post-treatment records

   It is less common for plans to cover:

   - Two-phase orthodontic treatment
   - Appliances to correct harmful habits like thumb-sucking
   - Jaw surgery to facilitate orthodontic treatment
   - Treatment to prepare for any non-covered surgical procedures

3. **Are retainers covered?**
   Typically, one set of post-treatment retainers (for orthodontic purposes) is covered in a lifetime. If your plan covers two-phase orthodontic treatment, retainers are usually covered after each phase.

[1] Your benefits may differ from the general information provided here. Review your plan booklet for specific details regarding your plan's orthodontic benefits, deductibles, maximums, waiting periods, limitations and exclusions.

[2] PPO network dentists usually offer the most cost savings; however, the Delta Dental Premier network also offers cost protections.

4. **Is Invisalign® covered?**
   Some plans may cover alternative appliances like Invisalign. If an appliance is not covered, Delta Dental usually covers some of the orthodontic treatment costs, which can reduce your overall expenses. If you're interested in Invisalign, ask your dentist to submit a pre-treatment estimate before you begin treatment.[3, 4]

Managing costs

5. **How much does orthodontic treatment cost?**
   Costs depend on the services you need, but Delta Dental can help estimate costs before treatment begins. Ask your dentist to submit a pre-treatment estimate to us, and we'll send you and your dentist an overview of the total treatment cost, including how much your plan pays and your share of the cost.[1, 3, 4]

6. **If I began treatment under a different dental plan, is work in progress covered?**
   Work in progress coverage depends on your plan, and is typically only available if you are undergoing active orthodontic treatment.[1, 5] If your plan covers work in progress, ask your orthodontist to submit an orthodontic treatment claim to us, including:
   - All charges and fees (including the down payment or installments paid by your previous dental plan)
   - Banding date and length of active treatment
   - Brief description of the dentition, appliance (including type) and treatment
   - If you are covered by more than one plan: information about the secondary carrier

7. **Are claims required for orthodontic treatments?**
   Delta Dental orthodontists will submit claims for you. If you choose a non–Delta Dental orthodontist, you may need to submit a claim to request reimbursement.

8. **When does Delta Dental make payments for orthodontic treatments?**
   Treatment under $500 is paid in one lump sum once banding has occurred. For treatment over $500, payments are made in two installments: once banding has occurred and 12 months later, depending on eligibility.

9. **Is my treatment subject to both the orthodontic lifetime maximum and regular annual maximum?**
   This depends on your group contract. Please check your plan booklet for more information.

[3] A pre-treatment estimate is not a guarantee of Delta Dental's final payment. When the treatment is complete, we will calculate our payment based on your current eligibility, applicable deductibles and maximums and any dual coverage you have.

[4] If you choose a non–Delta Dental orthodontist, you may need to submit a claim form yourself to obtain a pre-treatment estimate.

[5] Under some plans, you may lose eligibility if coverage has lapsed more than 30 or 60 days.

DELTA DENTAL

Expanded Coverage for Expecting Mothers

How the enhanced pregnancy benefit can protect your teeth

Expecting a baby? Being pregnant has major effects on the body, and your mouth is no exception. When you're pregnant, you're at higher risk for tooth decay and gum disease (also known as "pregnancy gingivitis").

That's why your dental plan offers enhanced coverage to pregnant women.

What's covered?

- 1 additional exam
- 1 cleaning or scaling and root planing

How do I use the benefit?

To use this benefit, just let your dentist know you're pregnant. The benefit will not be applied automatically. Your dentist must submit written confirmation of your pregnancy with your claim so that the claim is reprocessed to reflect the enhanced benefit.

deltadentalins.com/enrollees

EF33_ENH #120527 (4/19)

Vision Plan

We offer a VSP Choice vision plan through **The Standard**. Benefits are available once every 12 months. Members can choose either eyeglasses (which include frames and lenses) or contact lenses once every 12 months. Below are highlights of the plan and your monthly payroll contributions.

PROVIDER SEARCH: Visit www.standard.com/individual/products-services/workplace-benefits/insurance/vision, clicking "Find an Eye Doctor" and entering your search criteria.

Plan Highlights	Vision	
	In-Network	**Out-of-Network**
Exam (One every 12 months)	$4 Copay	Up to $45
Lenses (One every 12 months)		
Single	$10 Copay	Up to $30
Bifocal	$10 Copay	Up to $50
Trifocal	$10 Copay	Up to $65
Lenticular	$10 Copay	Up to $100
Frames (One every 12 months)	$120 allowance after $10 Copay	Up to $70
Contact Lenses[1] (One every 12 months)		
Standard Fit & Follow Up	$60 Copay	Not Covered
Elective	$110 allowance	Up to $105
Medically Necessary	Covered in Full	Up to $210
Monthly Payroll Contributions		
Employee Only	$3.65	
Employee + One	$6.57	
Employee + Family	$11.33	

City of Pembroke Pines - Policy #163591

Group Vision Insurance

Help protect your eye health with coverage for exams, glasses and contacts.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered vision care services.
NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 1: Balanced Care Vision I Plan Summary **Effective Date: 10/01/2024**

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$4 Exam	$4Exam
	$10 Eye Glass Lenses or Frames*	$10 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to $60	Not covered
Elective	Up to $110	Up to $105
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$120**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/12	12/12/12
	Based on date of service	Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco and Walmart allowance will be the wholesale equivalent.*

Lens Options (participant cost)*

	VSP Choice Network + Affiliates	Out of Network
	(Other than Costco)	
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	Not covered
Solid Plastic Dye	$15 (except Pink I & II)	Not covered
Plastic Gradient Dye	$17	Not covered
Photochromatic Lenses (Glass & Plastic)	$31-$82	Not covered
Scratch Resistant Coating	$17-$33	Not covered
Anti-Reflective Coating	$43-$85	Not covered
Ultraviolet Coating	$16	Not covered

**Lens Option participant costs vary by prescription, option chosen and retail locations.*

City of Pembroke Pines - Policy #163591

Additional Balanced Care Vision I Choice Network Features	
Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for participants is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Vision Plan Participant Service

Balanced Care Vision I from The Standard features the money-saving eye care network of VSP. Customer service is available to plan participants through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 800.877.7195

- Service representative hours: 5 a.m. to 7 p.m. Pacific Monday through Friday, 6 a.m. to 2:30 p.m. Pacific Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at:
www.standard.com/services

About The Standard

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

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

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard or your employer for additional information, including costs and complete details of coverage.

Smarter Vision Care™

VSP® is committed to the health and happiness of your employees. That's why we put them first, even going so far as to guarantee their satisfaction. No hassles, no excuses.

More Choice and Control

VSP Network—Your employees have the freedom to choose the provider that's right for them from up to **95,000 access points**, including the largest national network of independent doctors, popular retail chains, and a convenient online option. For added convenience, 91% of VSP network doctors offer early morning, evening, and weekend appointments, and 24-hour access to emergency care.

IndividualEyes® by VSP—Now it's easy to offer personalized coverage options with IndividualEyes by VSP. Whether you want to cover more designer frames or allow your employees to upgrade to a richer plan, we'll help you give your employees the choices and control they want most.

Spending Less, Getting More

Lowest Out-of-pocket Costs, Guaranteed

Your employees enjoy great every day savings on eye exams and glasses, as well as **Exclusive Member Extras** they can't get anywhere else. Without VSP, employees could pay $611 more for the same glasses!

Powerful Preventive Care

Since VSP network doctors are often first to detect signs of chronic conditions like diabetes, you'll enjoy substantial savings. **For every 100 employees, you can avoid $8,027** in lost productivity and healthcare costs with VSP.[2]

Award-winning Service

Concierge Transition Service™, best-in-class implementation plans and turnkey member communications make offering VSP easy. Employees enjoy exceptional care from our world-class-certified customer service team.

Choose VSP and see how you can get better choices smarter savings, and the best care. **Satisfaction guaranteed.**

VSP Network Providers

Local VSP Network Doctors

Participating Retail Chains Including:

Walmart

PEARLE VISION

Visionworks

HeartlandVision
YOU WON'T BELIEVE YOUR EYES.™

SVS VISION
OPTICAL CENTERS

Online Retail Store

eyeconic

*Your employees have the freedom to see any provider they choose. They'll get a generous out-of-network reimbursement schedule, and their provider can contact VSP to check eligibility and submit claims on their behalf.

1. Study was commissioned by VSP and conducted from November to December 2012. Study sample consisted of randomly selected geographically representative shops—nearly 850 independent doctor locations and nearly 450 retail chain locations. **2.** Human Capital Management Services (HCMS study on behalf of VSP, 2013).

Take Care of Your Vision

The Standard's‡ tips for protecting your eyes

It can be easy to forget to take care of your eyes. But that wouldn't be smart. Getting your eyes checked regularly can help your doctor spot other health issues, like diabetes or high blood pressure. Here are other ways to protect your vision:

Easy Ways to Protect Your Eyes

- **Wear sunglasses.** UV, or ultraviolet, light from the sun can increase your chance of getting cataracts or damaging your retinas. Sunglasses can help limit your exposure.
- **Wear safety glasses.** Use impact-resistant protective eyewear to avoid eye injuries when you're doing physical work or playing sports.
- **Take screen breaks often.** Screens can be a big part of our daily lives, but they can also lead to vision problems. Looking away for just 20 seconds can help give your eyes some needed rest.
- **Adjust your workspace.** Try these easy computer adjustments to help avoid screen-related eyestrain:
  - Center your monitor and place it an arm's length away.
  - Keep the top of your screen at eye level.
  - Reduce your screen brightness and increase the zoom.

Good Vision Helps Your Child Succeed in School

It's hard to learn when it's hard to see. Many kids may not know that they have poor eyesight, even when they have trouble seeing the front of the classroom. Regular eye exams can find vision problems and identify solutions to help your child succeed in school.

How Often Should You See the Optometrist?

Regular eye exams are the best way to keep your eyes healthy. Use this chart to see how often you and your family should see an optometrist.

Age	Exam Frequency
0–2 years	At 6 months old
2–5 years	At 3 years old
6–18 years	Every two years, starting in first grade
19–60 years	Every two years
61 and older	Once a year

This section will review the following

- **Life & AD&D**
- **Voluntary Life**
- **Disability Insurance**
- **Additional Benefits**

Life & AD&D

Basic Life & AD&D Insurance – Employer Paid

In the event of a death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

All full-time, active employees are eligible for Group Life & AD&D Insurance that will cover 1 time their covered annual earnings up to a maximum of $100,000 through **Standard Life**. Beginning on and after your 65th birthday, your life insurance benefit decreases.

Be sure to keep your beneficiary designations up to date! You can change your beneficiary designation at any time. You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.

Voluntary Life– New Hires Only

All full-time benefits eligible employees may purchase additional Life Insurance through **Standard Life**. There is not an annual enrollment on this coverage. Only new employees may apply for coverage. Evidence of Insurability may be required. Below are some coverage highlights.

Plan Highlights	Voluntary Life Coverage
Employee*	$10,000 increments to a maximum of $100,000
Dependents** *Packaged*	Spouse: $10,000 Child(ren) 14 days to 23 years if full-time student: $5,000

Bi-Weekly Payroll Cost

Employee's bi-weekly rate is determined by the Employee's age. See sample chart below. Supplemental Dependent Life Package bi-weekly rate is $4.94.

Age	Employee Bi-Weekly Rates per $1,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
<25	$0.037	$0.74	$1.11	$1.48	$1.85	$2.22	$2.59	$2.96	$3.33	$3.70
25-29	$0.037	$0.74	$1.11	$1.48	$1.85	$2.22	$2.59	$2.96	$3.33	$3.70
30-34	$0.042	$0.84	$1.25	$1.67	$2.08	$2.50	$2.91	$3.33	$3.74	$4.16
35-39	$0.042	$0.84	$1.25	$1.67	$2.08	$2.50	$2.91	$3.33	$3.74	$4.16
40-44	$0.074	$1.48	$2.22	$2.96	$3.70	$4.44	$5.17	$5.91	$6.65	$7.39
45-49	$0.120	$2.40	$3.60	$4.80	$6.00	$7.20	$8.40	$9.60	$10.80	$12.00
50-54	$0.203	$4.07	$6.10	$8.13	$10.16	$12.19	$14.22	$16.25	$18.28	$20.31
55-59	$0.415	$8.31	$12.47	$16.62	$20.77	$24.93	$29.08	$33.24	$37.39	$41.54
60-64	$0.614	$12.28	$18.42	$24.56	$30.70	$36.84	$42.97	$49.11	$55.25	$61.39
65-69	$0.868	$17.36	$26.04	$34.71	$43.39	$52.07	$60.74	$69.42	$78.10	$86.77
70-74	$2.003	$40.07	$60.10	$80.13	$100.16	$120.19	$140.22	$160.25	$180.28	$200.31

**Your dependent's insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. (Totally disabled means that, as a result of an injury, a sickness or a disorder, your dependent spouse is confined in a hospital or similar institution or is confined at home for sickness or injury; or has a life-threatening condition.)

Disability – New Hires Only

Voluntary Long-Term Disability (LTD)*

All full-time benefits-eligible employees may purchase Long-Term Disability Insurance through **The Standard**. Evidence of Insurability will be required if you previously waived or were declined coverage.

The Long-Term Disability Insurance is designed to protect your earnings for an extended disability. A monthly benefit will be paid based on 50% of your covered monthly earnings up to a maximum benefit of $5,000 per month. The policy includes a 90-day waiting period before benefits are payable. Benefits can be paid up to the later of age 65 or Social Security Normal Retirement Age if you meet the plan's disability requirements. This coverage includes a 3/12 pre-existing coverage condition exclusion.

Those enrolled in this disability coverage will automatically receive travel assistance services provided by Assist America. Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains
- Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability.

Contact Travel Assistance:
Easy access via the Assist America Mobile App
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda: 1-800-872-1414
Everywhere else: +1-609-986-1234
Text: +1-609-334-0807
Email: medservices@assistamerica.com

*Your benefit 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.

Premium Worksheet

Group Long Term Disability Insurance

City of Pembroke Pines

Scheduled Benefit: Each eligible employee may elect **50 %** of their monthly earnings, up to **5,000** per month benefit maximum.

To calculate your bi-weekly payroll deduction, use the formula indicated below:
(Round all numbers to the nearest whole number)

1. Enter your **Annual Earnings.**	1. $_____
2. **Divide** your annual earnings by 12 (monthly earnings). Average monthly income cannot exceed **5,000**	2. $_____
3. **Multiply** the amount on Line 2 by **.40**	3. $_____
4. **Divide** the amount on Line 3 by 100 and enter the amount on Line 4 to get your monthly payroll deduction.	4. $_____
5. **Multiply** the amount on Line 4 by 12, then **Divide** by 26 to get your bi-weekly payroll deduction.	5. $_____

Rate per $100 of covered payroll
.40

Example Calculation:

1. Enter your **Annual Earnings**	1. $ 50,000
2. **Divide** your annual earnings by 12 (monthly earnings). Average monthly income cannot exceed **5,000**	2. $ 4,167 (monthly earnings)
3. **Multiply** the amount on Line 2 by **.40**	3. $ 1,667
4. **Divide** the amount on Line 3 by 100 and enter the amount on Line 4 to get your monthly payroll deduction.	4. $ 16.67
5. **Multiply** the amount on Line 4 by 12, then **Divide** by 26 to get your bi-weekly payroll deduction.	5. $ 7.69 (bi-weekly payroll deduction)

Flexible Spending Accounts (FSA)

The month of August is your election period, and the new elections that you make will be effective for your plan year, which will start on **October 1, 2024 and runs through September 30, 2025.** *This is the only way that you can pay for some of your expenses before federal income tax and Social Security are taken from your check.* This short question and answer summary is a brief explanation of the plan.

What are the expenses that I can pretax?

- Your portion of the group medical, dental, vision, and voluntary insurance premiums
- Employment related dependent daycare expenses up to $5,000 annually
- Certain unreimbursed medical expenses up to $3,200 annually

What is our plan year?

Our plan year starts October 1, 2024 and ends on September 30, 2025. The extension period offers **extended dates of service from October 1, 2025 thru December 15, 2025 for both the medical claims and Dependent care claims. The grace period ends on December 31, 2025; all claims must be submitted to our office by December 31, 2025.**

Am I eligible to participate?

Yes, all full-time employees (regularly scheduled to work at least 30 hours per week) may participate on the 31st day of continuous fulltime employment.

What risk do I have?

Once you make your elections, you cannot change them unless you have a change in status recognized by the IRS**. If you do not use all the money that you have elected, YOU WILL LOSE IT.** Remember that Section 125 Plans work on date of service and not date of payment.

For this plan year, the medical and daycare expenses must be for services performed or benefits received on or after **October 1, 2024 and by December 15, 2025**. **The IRS has given you an 90 days to incur expenses following the end of the plan year if you are a participant on the last day of the plan year!**

If you terminate, the expense must be incurred while you are employed. You should be conservative in your elections, trying to maximize your tax benefits while trying to minimize your risk of forfeiting your money.

There is a 90-day grace period at the end of the plan year or your termination date, whichever comes first. This gives you some extra time to organize and submit your receipts. It does not give you extra time to incur expenses.

Administrative Services are provided by:

Diversified Administration, Inc.

6600 Taft Street, Suite 304
Hollywood, FL 33024
(954) 983-9970
Fax (954) 983-9695
www.div125.com
To send a claim through the e-mail system, e-mail: claims@div125.com

For resources, forms, and more information, please visit www.div125.com.

Eligible Expenses for Healthcare FSA

Examples of Allowable Expenses

- Deductibles
- Coinsurance
- Doctor's office visits
- Well-baby care
- Physicals and Checkups
- Pap Smears
- Mammograms
- Obstetrics
- Menstrual care products
- Immunizations
- Over-the-counter medication
- Prescription Drugs
- Contraceptives
- Insulin
- Ostomy Supplies
- Lab tests and diagnostics
- Crutches
- Splints
- Hearing aids
- Chiropractor visits
- Physical therapy
- Psychotherapy
- Routine dental care
- Crowns
- Fillings
- Bridges
- Dentures
- Orthodontia
- X-rays
- Eye exams
- Prescription glasses
- Contact lenses and solution
- Non-cosmetic surgery
- Prenatal vitamins
- Acupuncture
- Organ transplants
- Sterilizations
- Podiatric treatment
- Hospitalizations
- Home healthcare
- Lasik surgery
- Ambulances
- Guide dogs
- Prosthetics
- Wheelchairs
- Portable oxygen
- MRI & CAT scans

Examples that Require Signed Rx or Letter of Medical Necessity

- Weight loss prescriptions and programs (excluding food)
- Smoking cessation products and programs

Examples of Ineligible Expenses

- Cosmetic Surgery
- Hair Treatment
- Rogaine
- Herbs
- Nutritional Supplements
- Vitamins
- Sunglasses
- Toothbrushes
- Deodorants
- Health Club Fees
- Maternity Clothes
- Dental Floss
- Toiletries
- Diapers
- Moisturizers
- Q-tips
- Electrolysis
- Soap
- Baby Wipes
- Rx from Other Countries

Flexible Spending Accounts (FSA)

When do I submit my claims for reimbursement and when do I get the money?

You will receive the money in your paycheck shortly after the processing date. **We will be processing weekly.** Claims must be received on Tuesday by 4:00 p.m.: Date to be processed: **Wednesday**

*Any claim received after the cut-off date will be processed on the following regular day.

Remember – Use it or Lose It! You own your account, but funds are not carried to the next plan year. You must submit your claims and use your contributions or lose them at the end of the plan year.

First Time Login Instructions:

- Go to www.div125.com
- Click on For Employee Link
- Login ID field – type in SS# without spaces or dashes
- Skip the password field
- Enter employee code: **49545541**
- Enter email address
- Receive temporary password via email
- Log back on and enter SS# and temporary password
- You can then personalize your ID card and password
- Phone app: https://itunes.apple.com/us/app/myrsc/id561492867?mt=8

Dependent Account

There are two ways to get a tax break on your dependent care expenses. You can use either the income tax credit on Form 2441 of your 1040, or you can use the Section 125 Plan and get your benefit in every paycheck. Your tax advisor can help you decide which tax break will save the most money for your family. Single parents with an annual income of $24,000 or less may be better off using the tax credit and not the Section 125 Plan. That figure goes up to $35,000 for two wage earners in the family. If your income is higher than the above, you will generally want to use the Section 125 Plan and not the tax break.

What are Eligible Expenses?

Children's Daycare
Summer Day Camp

Before School
After School Care

Senior & Elder Dependent Care

Flexible Spending Accounts (FSA)

Who Qualifies as a Dependent?

A child under the age of 13 who lives with you, and whom you claim as a dependent on your tax return. Additionally, a spouse, parent, or other family member who is physically or mentally incapable of caring for himself or herself and is claimed as a dependent on your tax return.

What Else Do I Need to Know?

Expenses must enable you to be gainfully employed and be incurred during the plan year - both you and your spouse (if applicable) must be gainfully employed to participate in this benefit. The reimbursement may not exceed the maximum allowed under the plan, $5,000 if filing a joint tax return (or $2,500 if filing separate returns), or your taxable compensation.

What Expenses Count as Daycare?

Full time care from birth until the “grade” just before kindergarten can be provided by a caregiver or family member who is not the employee’s spouse or dependent under the age of 19. Children from kindergarten through age 12 (but not age 13) qualify for before school care, after school care, school’s out days, spring break, winter break, summer day camp (but not sleep-away).

How Much Will I Save if I Participate in this Plan?

Example: $100 Bi-Weekly Daycare Expense

Without Flexible Spending		With Flexible Spending	
$700.00	Earnings	$700.00	Earnings
$105.00	Federal Income Tax	$90.00	Federal Income Tax
$53.55	Social Security Tax	$45.00	Social Security Tax
$100.00	Bi-Weekly Daycare	$100.00	Bi-Weekly Daycare
$541.45	Take Home Pay	$600.00	Take Home Pay
$441.45	Disposable Income	$464.10	Disposable Income

$22.65 Savings Bi-Weekly

$588.90 Savings Per Year!

Flexible Spending Accounts (FSA)

FSA Election Instructions

Important: Microsoft Edge/Internet Explorer is not a supported browser for completing your enrollment

1. Visit https://www.div125.com/participants/participant-forms/fsa-online-enrollment-form/
2. Enter Your Employer Code **49545541** and click **Validate**
3. Enter the requested information into page 1 and click **Continue to Enroll** or **Decline Participation**
    a. You will get an email confirmation of your election or declined participation sent to the e-address entered on this page after you've submitted your election.
    b. If you choose to decline, confirm your choice in the pop-up window and you're done.
4. Enter your mailing address and click **Next**
    a. This is the address your debit card will be mailed to (and the billing address associated with the card)
5. Choose "how many times you are paid" from the drop down (if applicable)
6. Select Yes for any benefits you'd like to elect
    a. Enter your Annual or Per-pay deduction amount
    b. Check any required acknowledgement boxes
7. Select **No** for any Benefits you do not wish to elect
8. Click Confirm to proceed to the confirmation page.
    a. Review your election information, if incorrect, go Back
    b. If your election information is correct, you can check the boxes to get a PDF for immediate download (this is a full record of your election), and a simple email confirmation.
9. Once you click Submit, please allow up to 60 seconds for the form to submit your election and create your Election Confirmation PDF. You can click the blue hyperlink to download and save the PDF confirmation.
    a. You will also receive an email confirmation to the email address you provided on page 1 of the form.

Additional Benefits

The City of Pembroke Pines offers the opportunity to purchase voluntary worksite products through AFLAC. The premiums for these policies are available to you at a discount as an employee of the City of Pembroke Pines, however, you will need to enroll directly with AFLAC and the bill will be sent to you – payroll deduction for this coverage is not available. If you are currently enrolled in an AFLAC policy and would like to cancel it, please let our Human Resources Department know. The following products are available:

Short Term Disability Insurance

Pays a cash benefit based on your financial needs and income during a total or partial disability period.

Accident Indemnity Insurance

Pays cash benefits if a covered person's accidental death, dismemberment, or off-the-job injury is caused by a covered accident. The policy also includes a wellness benefit.

Cancer Indemnity Insurance

Pays cash benefits directly to you, unless assigned – giving you the flexibility to pay bills related to treatment like deductibles, copayments and travel expenses or everyday living expenses like your car payment, mortgage, childcare, etc.

Critical Care and Recovery Insurance

Complements your major medical coverage and pays a first-occurrence benefit, as well as hospital confinement and continuing care benefits to help provide the peace of mind that comes from knowing you and your family are protected.

To enroll, contact Gene Villa at 561-714-4224 or gene@definovilla.com

Employee Assistance Programs (EAP)

The City of Pembroke Pines offers Resources for Living, an Employee Assistance Program (EAP) through Aetna, at no cost. This program offers unlimited confidential counseling and referral services for employees and their household members 24 hours a day, 7 days a week. The program provides up to 5 sessions with a counselor per issue per year.

To access the EAP services, you can call 1-800-865-3200 or visit www.resourcesforliving.com and login (Login: Pembroke Pines FL; Password: EAP)

https://transparency-in-coverage.uhc.com/

Medicare Part D Creditable Coverage Notice

Important Notice from THE CITY OF PEMBROKE PINES About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with THE CITY OF PEMBROKE PINES and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **THE CITY OF PEMBROKE PINES has determined that the prescription drug coverage offered by the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in THE CITY OF PEMBROKE PINES coverage as an active employee, please note that your THE CITY OF PEMBROKE PINES coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in THE CITY OF PEMBROKE PINES coverage as a former employee.

You may also choose to drop your THE CITY OF PEMBROKE PINES coverage. If you do decide to join a Medicare drug plan and drop your current THE CITY OF PEMBROKE PINES coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with THE CITY OF PEMBROKE PINES and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through THE CITY OF PEMBROKE PINES changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	November 19, 2024
Name of Entity/Sender:	THE CITY OF PEMBROKE PINES
Contact--Position/Office:	Human Resources
Address:	601 City Center Way (3rd Floor – Suite #305), Pembroke Pines, FL 33025
Phone Number:	954-392-2090

Annual Notices

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in THE CITY OF PEMBROKE PINES's group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan. To request special enrollment or obtain more information, contact:

Human Resources
954-392-2090

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

New Health Insurance Marketplace Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

Part A: General Information
Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2 An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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)**	
City of Pembroke Pines	59-0908106	
5. Employer address	**6. Employer phone number**	
601 City Center Way (3rd Floor – Suite #305)	954-392-2090	
7. City	**8. State**	**9. Zip code**
Pembroke Pines	FL	33025
10. Who can we contact about employee health coverage at this job?		
Human Resources		
11. Phone number (if different from above)	**12. Email address**	
	drotstein@ppines.com	

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

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

  ☐ All employees.

  ☑ Some employees. Eligible employees are:

  - Employees working 30 or more hours per week.
- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  - Spouse or domestic partner and children to age 26 or 30, if they qualify

  ☐ 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.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

Alabama – Medicaid	Alaska – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
Arkansas – Medicaid	**California – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website:Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (Chp+)	**Florida – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
Georgia – Medicaid	**Indiana – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
Iowa – Medicaid And Chip (Hawki)	**Kansas – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012

Kentucky – Medicaid	Louisiana – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
Maine – Medicaid	**Massachusetts – Medicaid And Chip**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 | TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102 Email: masspremassistance@accenture.com
Minnesota – Medicaid	**Missouri – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
Montana – Medicaid	**Nebraska – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada – Medicaid	**New Hampshire – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
New Jersey – Medicaid and Chip	**New York – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

North Carolina – Medicaid	North Dakota – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
Oklahoma – Medicaid and Chip	**Oregon – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
Pennsylvania – Medicaid and Chip	**Rhode Island – Medicaid and Chip**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
South Carolina – Medicaid	**South Dakota - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
Texas – Medicaid	**Utah – Medicaid and Chip**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
Vermont– Medicaid	**Virginia – Medicaid And Chip**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
Washington – Medicaid	**West Virginia – Medicaid And Chip**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days or longer period permitted under the terms of the Plan, after the qualifying event occurs. You must provide this notice to the Plan Administrator.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Name of Entity/Sender:	THE CITY OF PEMBROKE PINES
Contact--Position/Office:	Human Resources
Address:	601 City Center Way (3rd Floor – Suite #305), Pembroke Pines, FL 33025
Phone Number:	954-392-2090

EEOC Wellness Program Notice

Notice Regarding Wellness Program

THE CITY OF PEMBROKE PINES's wellness program offered is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.
Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) "a registered nurse," "a doctor," or "a health coach" in order to provide you with services under the wellness program.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Plan Administrator.

Notice of Patient Protections

The carrier will generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, [name of group health plan or health insurance issuer] designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact HR.

For children, you may designate a pediatrician as the primary care provider.

Annual Notices

You do not need prior authorization from THE CITY OF PEMBROKE PINES or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact HR.

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The City of Pembroke Pines sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of The City of Pembroke Pines, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by The City of Pembroke Pines, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the The City of Pembroke Pines HIPAA Privacy Officer:

The City of Pembroke Pines
Attention: HIPAA Privacy Officer
Human Resources
954-392-2090

Effective Date

This Notice as revised is effective July 17, 2023.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period The City of Pembroke Pines has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-362-1116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-800-362-1116 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person / **$0** family In-network **$10,000** person / **Unlimited** family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	**$6,350** person / **$12,700** family In-network **Unlimited** person / **Unlimited** family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Copayments for certain services, penalties, deductible for out-of-network charges, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-362-1116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay per visit	50% Coinsurance	None
	Specialist visit	$20 Copay per visit	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge	50% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 Copay per visit PCP; $20 Copay per visit Specialist Office setting; $15 Copay per day Outpatient setting	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$15 Copay per visit PCP; $20 Copay per visit Specialist Office setting; $25 Copay per day Outpatient setting	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.umr.com.	Tier 1 (generic and some brand-name)	$10 Copay per prescription (retail); $20 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	Out-of-pocket limit applies Covers up to a 34-day supply (retail); 35-90 day supply (mail order); Covers up to a 31-day supply (specialty) You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, this difference is not applied to preferred brand-name products in the high priced generic strategy, until the Out-of-pocket is met
	Tier 2 (preferred brand-name and some generic)	$25 Copay per prescription (retail); $50 Copay per prescription (mail order)		
	Tier 3 (nonpreferred brand-name and nonpreferred generic)	$35 Copay per prescription (retail); $70 Copay per prescription (mail order)		
	Tier 4 (specialty drugs)	$20 Copay per prescription (Tier 1); $50 Copay per prescription (Tier 2); $70 Copay per prescription (Tier 3)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 Copay per visit	50% Coinsurance	None
	Physician/surgeon fees	$100 Copay per visit	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	$100 Copay per visit	$100 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$50 Copay per visit	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 Copay per admission	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Physician/surgeon fee	$150 Copay per admission	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copay per office visit; No charge other outpatient services	50% Coinsurance	None
	Inpatient services	$150 Copay per admission	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
If you are pregnant	Office visits	No charge	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	50% Coinsurance	
	Childbirth/delivery facility services	$150 Copay per admission	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	50% Coinsurance	120 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Rehabilitation services	$15 Copay per visit	50% Coinsurance	60 Maximum visits per calendar year
	Habilitation services	$15 Copay per visit	50% Coinsurance	
	Skilled nursing care	No charge	50% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Durable medical equipment	No charge	50% Coinsurance	Preauthorization is required for DME in excess of $1,000. If you don't get preauthorization, benefits could be reduced by 25% per occurrence.
	Hospice service	No charge	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Infertility treatment
- Private-duty nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

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

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-362-1116.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

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

UMR: CITY OF PEMBROKE PINES: 7670-00-510020 002

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-362-1116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-800-362-1116 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** person / **$600** family In-network **$600** person / **$1,000** family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	**$6,350** person / **$12,700** family In-network **$6,350** person / **$12,700** family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Copayments for certain services, penalties, deductible for out-of-network charges, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-362-1116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% Coinsurance	30% Coinsurance	None
	Specialist visit	10% Coinsurance	30% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	30% Coinsurance; Deductible Waived to age 17; Not covered from age 17	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	30% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.umr.com.	Tier 1 (generic and some brand-name)	$10 Copay per prescription (retail); $20 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	Out-of-pocket limit applies Covers up to a 34-day supply (retail); 35-90 day supply (mail order); 31-day supply (specialty) You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, this difference is not applied to preferred brand-name products in the high priced generic strategy, until the Out-of-pocket is met
	Tier 2 (preferred brand-name and some generic)	$25 Copay per prescription (retail); $50 Copay per prescription (mail order)		
	Tier 3 (nonpreferred brand-name and nonpreferred generic)	$35 Copay per prescription (retail); $70 Copay per prescription (mail order)		
	Tier 4 (specialty drugs)	$20 Copay per prescription (Tier 1); $50 Copay per prescription (Tier 2); $70 Copay per prescription (Tier 3)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	None
If you need immediate medical attention	Emergency room care	$100 Copay per visit; Deductible Waived	$100 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$50 Copay per visit; Deductible Waived	30% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Physician/surgeon fee	10% Coinsurance	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance	30% Coinsurance	None
	Inpatient services	10% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	30% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance	30% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	120 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Rehabilitation services	10% Coinsurance	30% Coinsurance	60 Maximum visits per calendar year
	Habilitation services	10% Coinsurance	30% Coinsurance	
	Skilled nursing care	10% Coinsurance	30% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% of the total cost of the service.
	Durable medical equipment	10% Coinsurance	30% Coinsurance	Preauthorization is required for DME in excess of $1,000. If you don't get preauthorization, benefits could be reduced by 25% per occurrence.
	Hospice service	10% Coinsurance	30% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Infertility treatment
- Private-duty nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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

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

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

About these Coverage Examples:

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

The plan's overall deductible	$300
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,460**

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

The plan's overall deductible	$300
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$800
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	$300
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-362-1116.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

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