



2027 GUIDEBOOK

PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS

Benefits That Bring It All Together.

Coverage and Support for Every Stage.



2027 Group Insurance
Information



Disclaimer: This guide does not contain an exhaustive list of the terms and conditions of each benefit. Please refer to the policy, certificate of coverage, or the carrier for more information. Information contained herein does not constitute an insurance certificate or policy. Certificates or policies will be provided to participants following the start of the plan year, if applicable. Additional information about your County benefits is available at www.pbc.gov/MyBenefits.

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IMPORTANT CONTACT INFORMATION

Palm Beach County Board of County Commissioners (BCC)

Risk Management/Group Insurance

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

Phone: 561-233-5400 ♦ Fax: 561-242-7184 ♦ Email: BCCMyBenefits@pbc.gov ♦ Website: www.pbc.gov /MyBenefits

Palm Tran - Human Resources Department

100 N Congress Ave, Delray Beach, FL 33445

Phone: 561-841-4237 ♦ Email: palm-benefits@pbcgov.org

Palm Beach County Supervisor of Elections (SOE)

SOE Human Resources

4301 Cherry Rd, West Palm Beach, FL 33409

Phone: 561-656-6217 ♦ Email: ruthie@votepalmbeach.gov ♦ ADP Portal (for benefits enrollment)

Online Benefits System for BCC and Palm Tran Employees

MyBenefits pbc.gov/MyBenefits

Insurance Carriers/Vendors

Benefit/Provider	Customer Service	Group Policy #
Medical: UnitedHealthcare (UHC) - www.myUHC.com On-site UHC customer service representatives: Evelyn Giraldo: evelyn_giraldo@uhc.com Leslie Smalley: leslie_smalley@uhc.com UHC/OptumRx Home Delivery Prescription Program	833-760-7892 561-233-5474 561-233-5463 833-760-7892	929250
Dental: UnitedHealthcare (UHC) - www.myUHC.com On-site UHC customer service representatives: Evelyn Giraldo: evelyn_giraldo@uhc.com Leslie Smalley: leslie_smalley@uhc.com	833-760-7892 561-233-5474 561-233-5463	929250
Life Insurance: Securian	833-365-0321 securian.com/pbcinsurance Medical Underwriting: 800-872-2214 Claims: 888-658-0193	70953
Short- and Long-Term Disability: UnitedHealthcare (UHC) www.myUHC.com - Short-Term Disability - Long-Term Disability	866-556-8298 myuhcfp.com On-site UHC customer service representatives: Evelyn Giraldo: evelyn_giraldo@uhc.com Phone Number: 561-233-5474 Leslie Smalley: leslie_smalley@uhc.com Phone Number: 561-233-5463	390381
Flexible Spending Accounts: P&A Group www.padmin.com	800-688-2611	
Voluntary Supplemental Benefits: Washington National	561-889-0482 Billing/Payroll Questions: FLBilling@optavise.com Claims Questions/Help: FLClaims@optavise.com Enrollment/Service Questions: Michael.Hogan@optavise.com	
UHC Vision Plan (part of MEDICAL) www.myUHC.com	833-760-7892	929250
Employee Assistant Program/EAP	561-233-5460	
Employee Well-Being Program	wellness@pbc.gov (561) 233-5447 or (561) 233-5436	

INTRODUCTION

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

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

- A. Palm Beach County Board of County Commissioners (BCC)
- B. Supervisor of Elections
- C. Palm Tran, Inc.

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

**A. Palm Beach County Board of County Commissioners
Risk Management/Group Insurance Department**

100 Australian Avenue, Suite 200
West Palm Beach, FL 33406
Telephone: 561-233-5400 Fax: (561) 242-7184
Email: BCCMyBenefits@pbc.gov

**B. Palm Beach County Supervisor of Elections Office
Human Resources**

4301 Cherry Road
West Palm Beach, FL 33409
Telephone: 561-656-6217
Email: ruthie@votepalmbeach.gov

**C. Palm Tran, Inc.
Human Resources Department**

100 N Congress Ave
Delray Beach, FL 33445
Telephone: 561-841-4237
Email: palm-benefits@pbcgov.org

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

AVAILABILITY OF SUMMARY HEALTH INFORMATION



As an employee, the health benefits available to you represent a significant component of your compensation package.

They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: **pbc.gov/MyBenefits**. A paper copy is also available, free of charge, by calling 561-233-5400. A Glossary is available on MyBenefits or can be requested by calling 561-233-5400 or email: BCCMyBenefits@pbc.gov.



PALM BEACH COUNTY EMPLOYEE WELL-BEING PROGRAM

SUPPORTING YOUR PHYSICAL, MENTAL, FINANCIAL AND SOCIAL WELL-BEING.

The Palm Beach County Employee Well-Being Program offers education, activities and resources to help you build healthy habits, strengthen your well-being and connect with others.

Four Pillars Of Well-Being

Physical: Movement, nutrition, preventive care and healthy habits.

Mental: Stress management, resilience, emotional well-being and support.

Financial: Financial confidence, education and resources for everyday decisions.

Social: Connection, belonging, community and supportive relationships.

Explore Programs And Activities

- Preventive health opportunities, including biometric screenings, mammograms, dermatology exams, flu shots and vaccinations.
- Year-round fitness, in person and virtually, including 5K walk/run events, step challenges, Pilates, Zumba, yoga, and Pickle Ball classes. All BCC employees and their UHC-insured dependents ages 14 and older are eligible.
- Lunch & Learns led by subject matter experts, book clubs, and social gatherings that encourage connection.
- In-person and virtual mental and behavioral health workshops on stress management, self-care, mindfulness, resilience and emotional intelligence, including Mental Health First Aid training. Connections to the Employee Assistance Program (EAP) provide additional mental health support.

Well-Being Tools And Rewards

Additional well-being resources are available to eligible employees, including One Pass Select fitness memberships, weight-management and wellness coaching, mindfulness tools and discounted WW memberships.

Eligible employees can also earn wellness incentive rewards through Be Well. Be Rewarded., powered by UHC Rewards. Review current program information for qualifying activities, reward options and deadlines.

Eligible UnitedHealthcare (UHC) medical plan members can access additional programs through the UnitedHealthcare app. Select Benefits → Additional Benefits → View All.

Get involved and stay connected

Watch for weekly and monthly well-being emails, County-e-Line and the Well-Being Bulletin. Connect with your department's Wellness Coordinator and review event announcements for registration and participation requirements. Coordinate with your supervisor when attending activities during work hours.

Explore current programs and events: PBC Well-Being website at pbbocc.fbmcbenefits.com/well-being-program/

Contact the Well-Being Team: wellness@pbc.gov | (561) 233-5447 or (561) 233-5436



Be Well. Be Rewarded.

Palm Beach County Board of County Commissioner's
2027 Well-Being Incentive Program
Powered by UHC Rewards



TRACK ACTIVITIES

Earn once per plan year:

Connect a tracker	\$10
Track 14 nights of sleep	\$5

Earn Daily:

Daily activity - goal 1: Track 15 active minutes or 5k steps per day	\$0.25
Daily activity - goal 2: Track 30 active minutes or 10k steps per day	\$0.50

Earn Weekly:

Fitness challenge: Track 30 active minutes or 10k steps, 5 out of 7 days	\$2.50
Sleep challenge: Get 7 hours of sleep, 5 of 7 nights	\$2.50



PREVENTIVE CARE ACTIVITIES

Earn once per plan year:

Get a flu shot	\$15
Get an annual checkup	\$75
Get a cervical cancer screening	\$25
Get a breast cancer screening	\$25
Get a colorectal cancer screening	\$25
Get a biometric screening	\$25



ADDITIONAL ACTIVITIES

Earn once per plan year:

Complete a 24/7 Virtual Visit	\$25
Take a health survey	\$25
Complete a Real Appeal Coaching Session / Complete three Wellos 1:1 Coaching Sessions / Track using a Wellos Tracker for 5 separate days	\$25 each



On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards and start earning

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you - and start earning

\$200

maximum annual
incentive

Complete your actions by December 31, 2027 - Redeem by April 30, 2028

GOT QUESTIONS?

Your UHC Rewards customer service representative is ready to help
Call 866-230-2505 | Monday - Friday 8:00 AM - 7:00 PM EST

Palm Beach County Employee Well-Being Program - (561) 233-5447 or (561) 233-5436 | wellness@pbc.gov

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

ENROLLMENT GUIDE FOR NEW EMPLOYEES

New Hire Effective Date of Coverage:

Group insurance coverage for new hires will become effective the first of the month following or coinciding with 60 days of employment. For example, if your date of hire is May 15th, your group insurance benefits will be effective August 1st.

Electing your New Hire Coverage: pbc.gov/MyBenefits

You will elect your Group Insurance benefits through your benefits enrollment system, MyBenefits. You can access MyBenefits two weeks after your date of hire; make your elections starting **within 31 calendar days of your hire date**. You will receive an email that you can access MyBenefits to make your elections. If you don't have access to email, your supervisor will be notified when MyBenefits is ready for you. The system is available 24/7.

Signing In to MyBenefits:

You will need to use the network User ID and Password you have been assigned as a new hire and which you would also use to access HRIS for your paycheck information. Please note it takes 24 hours for you to be able to use your network user ID and password, once issued. Once you sign in to MyBenefits, it will automatically log you out after 15 minutes of inactivity. You can hit any key to reset the clock during an active session. If you have difficulty with your sign-in or need help with your user name and password, please contact the **OTI Help Desk at 561-355-HELP (4357)** during normal business hours.

Dependent Coverage:

If you wish to enroll your dependents in medical and dental coverage, you have to elect coverage for yourself. Dependent verification documentation is required before coverage for your dependents can become effective.

Please refer to the Eligibility Documents section in this guide book for acceptable dependent verification documents. All required documents **MUST** be received in your Group Insurance office within 60 calendar days of your date of hire. If the required information is not received, your dependents will not be enrolled in the plans that you have elected for them. All Such dependents will not be eligible for coverage until the next applicable annual Open Enrollment period, except in the case of a qualifying event.

Opt-Out Proof:

Proof of current medical coverage under another plan is required if you decline/waive medical coverage in MyBenefits, and you are eligible for the Opt-Out benefit. The proof must clearly include your name as an insured. Please note, if you are qualified for Opt-Out benefits, but fail to submit the documentation to your group insurance office, you will not be enrolled in the Opt-Out credit benefits.

Evidence of Insurability (EOI) for Life Insurance:

As a new hire, for additional life coverage greater than \$300,000 and for spousal/domestic partner life coverage greater than \$50,000, you/your spouse or domestic partner will have to successfully complete medical underwriting for coverage above these stated amounts. You or your spouse/ domestic partner will complete the EOI process with the carrier, Securian.

If you do not complete the EOI process with Securian, your coverage will be unable to be processed in excess of any guarantee issue amounts and cannot be considered for approval. Any coverage amounts subject to EOI must be approved by the carrier before the coverage can be added. Please contact Securian at 1-866-889-6221 with any questions regarding the EOI process.

Late Enrollment:

If you do not elect coverage as a new hire and within the first 31 days of your date of hire, you and your spouse/domestic partner will be subject to the EOI process. During the annual enrollment opportunity you can increase additional life coverage by one level increment of \$10,000 or spouse/domestic partner life coverage by one level increment of \$5,000 without providing EOI, as long as the resulting additional life does not exceed \$300,000 and the resulting spouse life does not exceed \$50,000.

However, the following elections will always require successful completion of the EOI process:

- Additional life coverage requests over \$300,000
- Spouse/domestic partner life coverage requests over \$50,000

Employees or spouses/domestic partners who were previously declined for coverage by Securian must provide EOI for any coverage increases.

If EOI is required, the requested coverage must be approved by the carrier for coverage to become effective.

Late enrollment for short-term or long-term disability benefits, or long-term disability upgrade requests are also subject to EOI if elected outside of your new hire election period, and outside of the annual enrollment period (e.g. applying for short term disability following a qualified family status change).

Primary Care Physician (PCP) Requirement:

A PCP election is required if you enroll in the UHC medical HMO or POS coverage. Please make sure to elect a PCP for yourself and any of your enrolled dependents at the time of your enrollment in MyBenefits. If you are assigned default medical benefits, please contact the UHC Onsite Service Account Managers for assistance with electing your PCP – prior to your coverage effective date.

UHC Onsite Service Account Managers:

- Evelyn Giraldo 561-233-5474 Evelyn_Giraldo@uhc.com
- Leslie Smalley 561-233-5463 Leslie_Smalley@uhc.com

Alternatively, you can also contact UHC at 833-760-7892 or go online at myUHC.com 24/7 for assistance.

Please be aware if you do not select a PCP for the HMO or POS plan, UHC will automatically assign one which may not be your physician of choice; this could cause you and your dependents a delay in medical care or obtaining any necessary referrals.

GROUP INSURANCE PLAN BENEFITS RATES

Medical Insurance –UnitedHealthcare (UHC– The County shares the cost of the premium with employee

Plans	Level of Coverage	Actual Cost	Monthly Employer Portion	Biweekly Employer Portion	Monthly Employee Portion	Biweekly Employee Portion
HMO	EE Only	\$957.00	\$926.00	\$463.00	\$31.00	\$15.50
	EE + 1	\$1,962.00	\$1,761.00	\$880.50	\$201.00	\$100.50
	EE + 2 or more	\$2,679.00	\$2,339.00	\$1,169.50	\$340.00	\$170.00
	Overage Dep*	\$574.00	\$0.00	\$0.00	\$574.00	\$287.00
CHOICE	EE Only	\$996.00	\$947.00	\$473.50	\$49.00	\$24.50
	EE + 1	\$2,036.00	\$1,761.00	\$880.50	\$275.00	\$137.50
	EE + 2 or more	\$2,781.00	\$2,339.00	\$1,169.50	\$442.00	\$221.00
	Overage Dep*	\$598.00	\$0.00	\$0.00	\$598.00	\$299.00
POS	EE Only	\$1,054.00	\$987.00	\$493.50	\$67.00	\$33.50
	EE + 1	\$2,123.00	\$1,795.00	\$897.50	\$328.00	\$164.00
	EE + 2 or more	\$2,904.00	\$2,403.00	\$1,201.50	\$501.00	\$250.50
	Overage Dep*	\$632.00	\$0.00	\$0.00	\$632.00	\$316.00

*Overage Dependent: Additional amounts for each dependent age 26–30 are added to other coverage rates and are 100% employee-paid; deducted post-tax beginning the year the dependent turns 27.

Dental Insurance – UnitedHealthcare – Premiums are 100% employee paid

Plans	Basic DHMO	Low PPO	High PPO	Enhanced DHMO	Premier PPO
Level of Coverage	Monthly Cost/ Biweekly Ded	Monthly Cost/ Biweekly Ded	Monthly Cost/ Biweekly Ded	Monthly Cost/ Biweekly Ded	Monthly Cost/ Biweekly Ded
EE Only	\$12.18 mo / \$6.09 biwkly	\$19.50 mo / \$9.75 biwkly	\$38.16 mo / \$19.08 biwkly	\$15.62 mo / \$7.81 biwkly	\$47.26 mo / \$23.63 biwkly
EE + 1	\$20.82 mo / \$10.41 biwkly	\$37.02 mo / \$18.51 biwkly	\$73.14 mo / \$36.57 biwkly	\$27.34 mo / \$13.67 biwkly	\$90.60 mo / \$45.30 biwkly
EE + 2	\$28.20 mo / \$14.10 biwkly	\$45.30 mo / \$22.65 biwkly	\$84.48 mo / \$42.24 biwkly	\$33.86 mo / \$16.93 biwkly	\$104.66 mo / \$52.33 biwkly
EE + 3 or more	\$37.22 mo / \$18.61 biwkly	\$62.88 mo / \$31.44 biwkly	\$119.50 mo / \$59.75 biwkly	\$43.00 mo / \$21.50 biwkly	\$148.02 mo / \$74.01 biwkly

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

FLEXIBLE SPENDING ACCOUNTS – P&A Group - Contributions are based on 26 pay periods

- Healthcare FSA contributions: **\$260 min \$3,400* max annually** or \$10.00 \$130.77 bi-weekly
- Dependent Care FSA contributions: **\$260 min \$7,500 max annually** or \$10.00 min – \$288.46 bi-weekly

*Annual limit will be increased to inflation adjusted amount, once announced by IRS

Short Term Disability Insurance – UnitedHealthcare

- EE Only - Weekly benefit is 67% of gross/max \$1200/week.
- **100% employee paid** Premium of \$.26 calculated on \$10 of weekly benefit.
- Example: $\$50,000 \div 52 \text{ weeks} \times 67\% \times \$.26 \div 10 = \text{monthly premium} \div 2 = \$8.38 \text{ bi-weekly}$

Long Term Disability Insurance – UnitedHealthcare

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

Voluntary /Buy-Up LTD – UnitedHealthcare

- **Voluntary /Buy-Up LTD** – EE Only - Monthly benefit is 60% of monthly gross / max \$5,000/month.
- **100% employee paid.** Cost is based on salary. Use formula to calculate rate:
 - Employee with HMO/CHOICE: $\text{Annual salary} \div 12 \text{ months} \times .00320 - \$3.20 = \text{monthly} \div 2 = \text{bi-weekly rate}$
 - Employee without HMO/CHOICE: $\text{Annual salary} \div 12 \text{ months} \times .0041 = \text{monthly} \div 2 = \text{bi-weekly rate}$
- Example: HMO/CHOICE EE @ \$50,000/year will pay \$5.07 bi-weekly ♦ Non-HMO/Non-CHOICE EE @ \$50,000 will pay \$8.54 bi-weekly

Term Life & AD&D Insurance/Additional Life & AD&D/Spouse Life & AD&D/Child Life – UnitedHealthcare

- **Free Basic Term Life:** EE Only - \$25,000 + \$15,000 AD&D coverage - 100% employer paid
 - **Additional/Supplement Life & AD&D** – EE Only - \$10,000 increments up to \$500,000 – 100% employee paid
 - **Spouse Term Life and *Spouse AD&D Insurance** - 100% employee paid
 - \$5,000 increments up to \$100,000 not to exceed 100% of employee's total coverage
- **Child Life:** \$5,000 or \$10,000 coverage amount - 100% employee paid
- There may be a slight variance of life insurance premiums reflected on paycheck due to rounding

All Rates are subject to change.

Term Life & AD&D Insurance/Additional Life & AD&D/Spouse Life & AD&D/Child Life Rates

Employee Coverage Amount	Bi-weekly Rate	Coverage Amount	Bi-weekly Rate	Spouse Coverage Amount	Bi-weekly Rate
\$10,000.00	\$1.46	\$260,000.00	\$37.96	\$5,000.00	\$0.73
\$20,000.00	\$2.92	\$270,000.00	\$39.42	\$10,000.00	\$1.46
\$30,000.00	\$4.38	\$280,000.00	\$40.88	\$15,000.00	\$2.19
\$40,000.00	\$5.84	\$290,000.00	\$42.34	\$20,000.00	\$2.92
\$50,000.00	\$7.30	\$300,000.00	\$43.80	\$25,000.00	\$3.65
\$60,000.00	\$8.76	\$310,000.00	\$45.26	\$30,000.00	\$4.38
\$70,000.00	\$10.22	\$320,000.00	\$46.72	\$35,000.00	\$5.11
\$80,000.00	\$11.68	\$330,000.00	\$48.18	\$40,000.00	\$5.84
\$90,000.00	\$13.14	\$340,000.00	\$49.64	\$45,000.00	\$6.57
\$100,000.00	\$14.60	\$350,000.00	\$51.10	\$50,000.00	\$7.30
\$110,000.00	\$16.06	\$360,000.00	\$52.56	\$55,000.00	\$8.03
\$120,000.00	\$17.52	\$370,000.00	\$54.02	\$60,000.00	\$8.76
\$130,000.00	\$18.98	\$380,000.00	\$55.48	\$65,000.00	\$9.49
\$140,000.00	\$20.44	\$390,000.00	\$56.94	\$70,000.00	\$10.22
\$150,000.00	\$21.90	\$400,000.00	\$58.40	\$75,000.00	\$10.95
\$160,000.00	\$23.36	\$410,000.00	\$59.86	\$80,000.00	\$11.68
\$170,000.00	\$24.82	\$420,000.00	\$61.32	\$85,000.00	\$12.41
\$180,000.00	\$26.28	\$430,000.00	\$62.78	\$90,000.00	\$13.14
\$190,000.00	\$27.74	\$440,000.00	\$64.24	\$95,000.00	\$13.87
\$200,000.00	\$29.20	\$450,000.00	\$65.70	\$100,000.00	\$14.60
\$210,000.00	\$30.66	\$460,000.00	\$67.16		
\$220,000.00	\$32.12	\$470,000.00	\$68.62		
\$230,000.00	\$33.58	\$480,000.00	\$70.08		
\$240,000.00	\$35.04	\$490,000.00	\$71.54		
\$250,000.00	\$36.50	\$500,000.00	\$73.00		

Child Life Coverage amounts of **\$5,000** and **\$10,000**:

\$5,000 coverage amount @ premium rate of \$0.15 bi-weekly;

\$10,000 coverage amount @ \$0.29 bi-weekly

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

THE COUNTY'S GROUP INSURANCE PLANS



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

- Medical Insurance - UnitedHealthcare (UHC)
- Dental Insurance - UnitedHealthcare (UHC)
- Term life Insurance - Securian
- Short-term Disability - UnitedHealthcare (UHC)
- Long-term Disability - UnitedHealthcare (UHC)
- Flexible Spending Accounts program - P&A Group
- Voluntary supplemental benefits (Accident, Cancer, Hospital) – Washington National
- Additionally, the County offers a benefit incentive for qualified employees who decline medical insurance or “opt-out” of the Group’s medical plan because they are otherwise covered under another qualified medical plan.

Plan Documents, Contracts and Publications

This guidebook describes generally benefits available to you under the various group plans. For detailed coverage information, exclusions and stipulations, please refer to the plan documents or contact your group insurance office or representative. All benefits under the group medical plan are provided pursuant to contracts between the County and various carriers. In the event of any inconsistencies between those contracts and this guidebook, or any omissions from this guidebook, the terms of contract shall prevail.

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

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

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

ONLINE BENEFITS ENROLLMENT & INFORMATION SYSTEM

MYBENEFITS SYSTEM

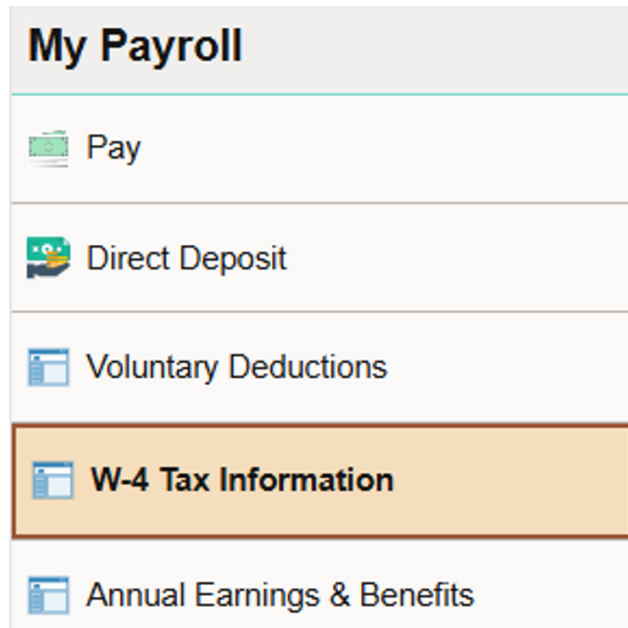
Online enrollment is the required method for Board of County Commissioners and Palm Tran employees to enroll for group insurance benefits. Supervisor of Election employees will receive enrollment instructions from their group insurance office or representative. Online enrollment allows you to have access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

Use **MyBenefits** to review your group insurance information and dependent information. **MyBenefits** is available year-round for you to view your coverage and dependent information,

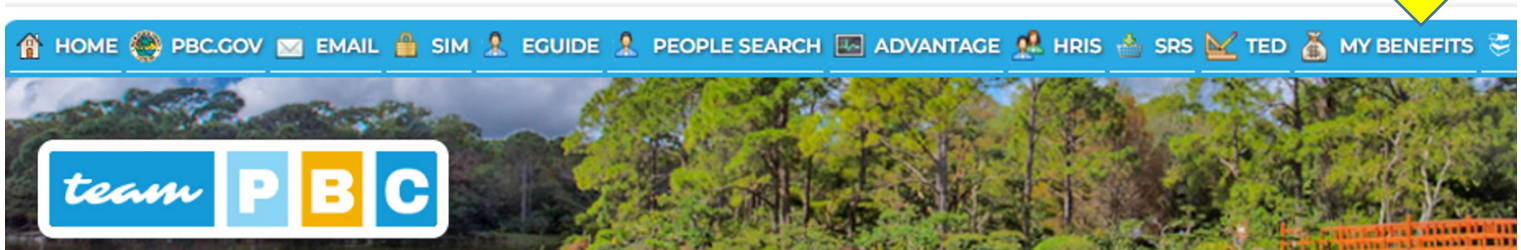
Benefits Enrollment - as a new hire and during the annual open enrollment period, you will be able to use **MyBenefits** to review benefit options and costs, and make elections and changes. Go to “Benefits Enrollment” and click the Start button next to the enrollment event to make or change your benefits choices within your enrollment period.

Other useful tasks you can accomplish in **MyBenefits**:

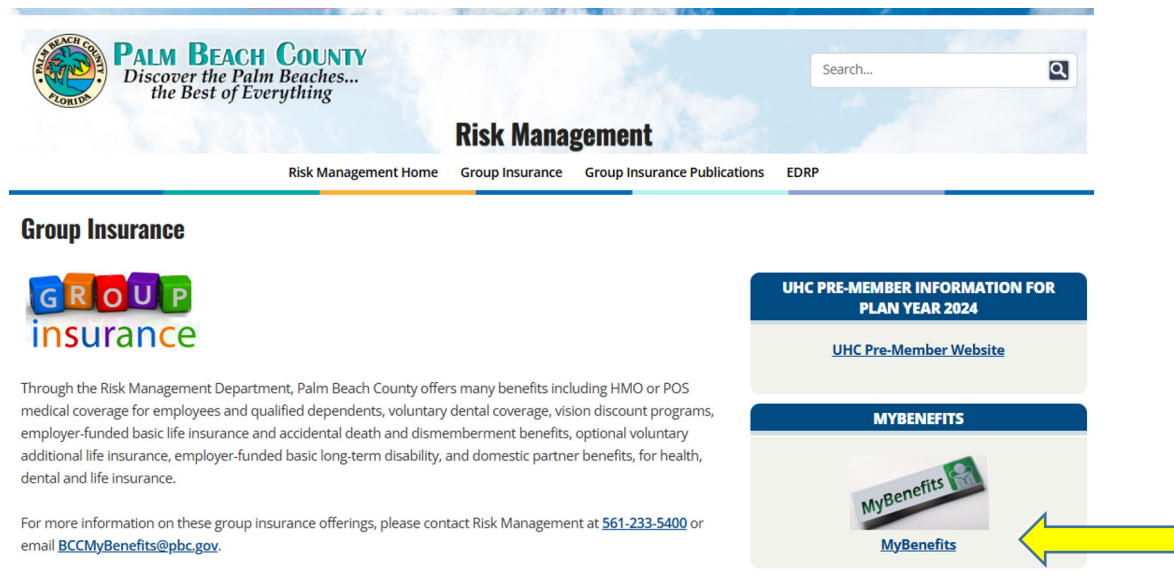
- Review/print your paychecks by selecting County Payroll
- Opt-in to electronically receive your W-2 annual tax form –W-2/W-2c Consent
- View and print your current and prior year W-2 tax form –W-2/W-2c Forms
- Opt-in to electronically receive your 1095-C annual tax form –Form 1095-C Consent
- View and print current and prior year 1095-C forms –View Form 1095-C
- Under My Payroll you can also manage your Direct Deposit and W-4 Tax Information



Step 1: Access www.pbc.gov/mybenefits, Click on the link to MyBenefits from the County's intranet page, MyPBC



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



Step 3: Enter your County issued User Name as the User ID (ALL CAPS) and Password (Case Sensitive) and click "Sign In":

ORACLE PeopleSoft

User ID

Password

Select a Language

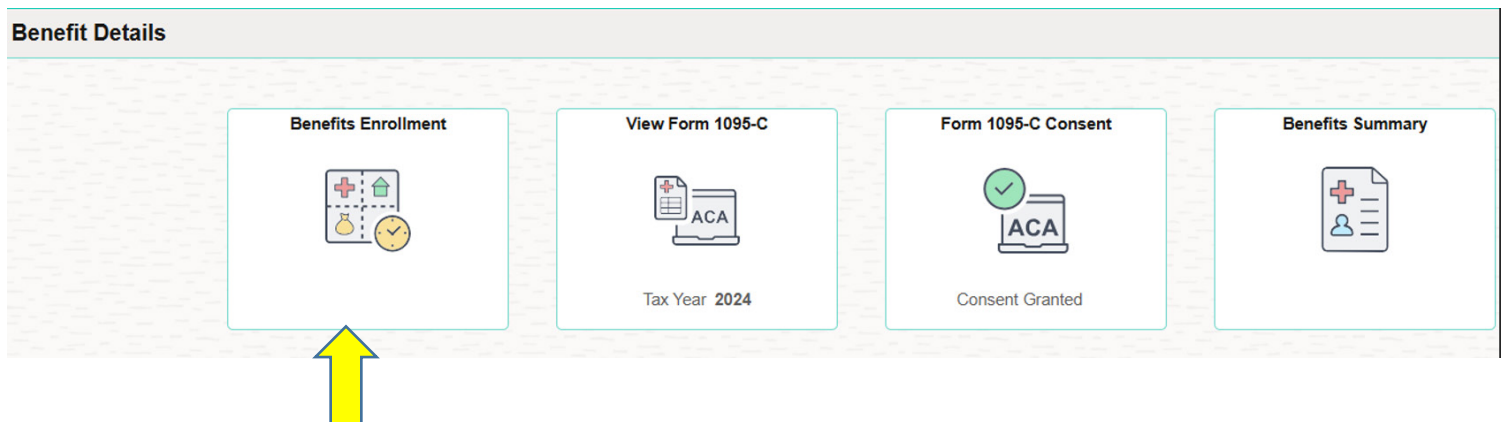
☐ Enable Screen Reader Mode

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

Step 4: Use the tiles to navigate to “Benefit Details” in the Employee Self Service application:



Step 5: Use MyBenefits to review your group insurance information and dependent information. MyBenefits is available year-round for you to view your coverage and dependent information.



GROUP INSURANCE ELIGIBILITY

Employee Eligibility

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

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

Dependent Eligibility

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

- Legal Spouse or Domestic Partner of the same or opposite sex who is not eligible for coverage as an employee. Note: A former spouse is NOT an eligible dependent and must be removed from an employee’s coverage immediately following a divorce – even if a court order mandates that the employee has to continue to provide medical coverage for the former spouse.

IMPORTANT: You **CANNOT** be covered as a dependent on the medical, dental, or life insurance plans if you are eligible for coverage as an employee.

- Natural, adopted, stepchild, domestic partner child, foster child, a child placed in your custody by a court order until the end of the month the child turns age 26 for medical, dental insurance or dependent (child life) insurance coverage
- A child born to an insured Dependent child of yours until such child is 18 months old

Qualified child from age 26 until the end of the calendar year in which the child reaches the age of 30 (provided child is unmarried and does not have a dependent of their own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of their own or entitled to benefits under title XVIII of the Social Security Act) may be covered for medical and dental plans.

IMPORTANT: The rates for children in this category are illustrated in the “Over-aged Dependent Tier”; are paid entirely by the employee electing the coverage for each 26 - 30 year old dependent and are paid IN ADDITION to other selected tiers of coverage. These additional premiums are paid on a post-tax basis beginning in the calendar year in which the dependent turns 27 Over-aged Dependents cannot participate in the life insurance plans

- Qualified child who is 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. The carrier will require supporting documents to approved coverage and periodically thereafter.

IMPORTANT: Your dependents who no longer meet the County’s eligibility requirement can no longer

remain under the group insurance plan, this includes a former spouse. Your group insurance office or representative will notify you 60 days before the coverage ends, due to age, and your dependent will be offered continuation coverage. If you experience a relevant qualifying event, it is your responsibility to notify your group insurance office or representative within 30 days of the event.

Employees May Not be covered as Dependents

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

Proof of Eligibility

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

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

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

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

DEPENDENT DOCUMENTATION

Refer to the following chart for required documentation:

Eligibility Categories	Required Documents:
- Legal spouse - Domestic partner of the same or opposite sex	- Copy of page 1 of federal tax return of most current tax year as filed (personal and income information redacted) listing spouse OR: Copy of marriage license/certificate; executed and recorded - Certificate or copy of executed, notarized and recorded Declaration of Domestic Partnership form (Ord. 2006- 002) PLUS (Spouse OR Domestic Partner) Proof marriage/partnership is still current (recurring monthly or quarterly household bill or statement of account listing spouse's/partner's name at employee's address within the past 60 days)
Child up to end of the month the child turns age 26	
Biological child	Official birth certificate (hospital birth record not acceptable)
Adopted child	Official adoption documents
Foster child	Official documents, placing the child in employee's care
Child placed into custody by a court order	Court documented guardianship papers (Power of Attorney is not acceptable)
Stepchild	Executed, recorded marriage license/certificate of marriage to biological parent of child and birth certificate for child that names the employee's spouse as a parent
Child of Domestic Partner	- Birth verification as indicated above, depending on type of child (biological, adopted, foster child, or child placed into custody of Domestic Partner by a court order) plus executed, notarized and recorded Declaration of Domestic Partnership form (Ord. 2006- 002) PLUS - Proof partnership is still current (recurring monthly or quarterly household bill or statement of account listing partner's name at employee's address within the past 60 days)
Child up to age 18 months	
Child born to an insured dependent of the employee	Official birth certificate of child born to the employee's insured dependent

Eligibility Categories	Required Documents:
Child age 26 to 30	
Unmarried child age 26 up to until the end of the calendar year in which the child reaches the age of 30, provided child does not have a dependent of his/her own, is a Florida resident or a full-time or part-time student, and is not covered under a plan of his/her own or entitled to benefits under Title XVIII of the Social Security Act.	• Official birth certificate (hospital birth record not acceptable) • Copy of driver's license OR State-issued ID showing s/he is a Florida resident OR • Copy of current school registration, confirming full-time or part-time student status
Disabled Child	
Qualified child who is 26 or more years old and primarily supported by the employee and incapable of self-sustaining employment by reason of mental or physical handicap	• Official birth certificate (hospital birth record not acceptable) • Official adoption documents • Official documents, placing the child in employee's care • Court documented guardianship papers (Power of Attorney is not acceptable)
Documentation required for other qualified events	
Type of family status change	Documentation
Dissolution of Domestic Partnership	Executed, notarized and recorded Declaration of Termination of Domestic Partnership form (Ord. 2006-002)
Divorce (divorced spouses are not eligible for dependent coverage regardless of the court decree)	Final Divorce Decree
Death	Death certificate

ENROLLMENT OPPORTUNITIES

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

- 1. Newly Hired Employees:** As a new hire you must elect your benefits within 31 calendar days by accessing MyBenefits within 31 days of your date of hire and also provide the following documentation:
 - Dependent verification documentation as specified above
 - Proof of other health insurance if you decline/waive medical coverage and are eligible for the Opt- Out benefit
 - Completed Evidence of Insurability forms – if required – for group term life insurance
- 2. After a Family Status Change or Life Event:** Employees or dependents that experience a Qualifying Event (QE) normally have 30 days from the date of the QE to make any changes to their benefits. QEs include family status changes such as marriage, divorce, beginning or ending of a domestic partnership, death of a spouse or dependent, birth or adoption/placement for adoption of a child, loss of other healthcare coverage or loss of dependent eligibility, change in spouse's/domestic partner's employment status, and initial entitlement to Medicare or Medicaid. If you experience a qualifying event, you must contact your respective group insurance office or representative to make appropriate changes to your coverage within 30 days of the date of the event. Any change in your benefits must be consistent with the change in status. For example, if you get married, you may add your spouse to your medical coverage. If you do not report a Life Event within 30 calendar days of the event date, you will not be able to enroll, change or cancel benefits until the next annual Open Enrollment period and the change will not take effect until January 1st of the following year.
- 3. During the annual Open Enrollment period** – Typically, Open Enrollment takes place each year beginning in the month of October. Employees are given the opportunity to review benefit plan options and make changes for the following plan year. All benefits chosen during Open Enrollment take effect on January 1st of the following year. The annual Open Enrollment period and information is widely communicated in advance.

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

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

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

COVERAGE EFFECTIVE DATES



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

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

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

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

PREMIUM AND PAYROLL DEDUCTION

Premium Costs

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

Pretax Benefit Plans

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

Payroll Deductions

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

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

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

DOMESTIC PARTNER BENEFITS



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

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

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

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

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

Eligibility for Domestic Partner Benefits

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

Premiums and Tax Implications for Domestic Partner Benefits

- The IRS allows employees to receive "tax-free" insurance subsidies for themselves and their eligible dependents as defined under IRS guidelines

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

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

Domestic Partner Tax Equity Policy

Please review Domestic Partner Tax Equity Policy PPM# CW-P-082 which has the purpose of creating a compensation structure which will fund a tax equity policy for County employees with eligible domestic partners enrolled in the County’s sponsored health insurance plans. PPMs are posted on the MyPBC Intranet under Publications > PPMs.

Domestic Partners and Medicare

- Domestic Partners may be subject to a Medicare Part B late enrollment penalty if they fail to enroll in Medicare Part B when first eligible.
- Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age.
- Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and UnitedHealthcare is the Secondary Plan
- If your Domestic Partner does not elect to enroll in Medicare Parts A and/or B when first eligible, the UnitedHealthcare medical plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled.
- However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules, as applicable, will apply.



OPT-OUT BENEFITS

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

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

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

MEDICAL BENEFITS

UNITEDHEALTHCARE (UHC)



The County offers a Health Maintenance Organization (HMO), a National Choice Open Access Plan (CHOICE), and a Point of Service plan (POS) through UHC

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

Plans	Level of Coverage	Actual Cost	Monthly Employer Portion	Biweekly Employer Portion	Monthly Employee Portion	Biweekly Employee Portion
HMO	EE Only	\$957.00	\$926.00	\$463.00	\$31.00	\$15.50
	EE + 1	\$1,962.00	\$1,761.00	\$880.50	\$201.00	\$100.50
	EE + 2 or more	\$2,679.00	\$2,339.00	\$1,169.50	\$340.00	\$170.00
	Overage Dep*	\$574.00	\$0.00	\$0.00	\$574.00	\$287.00
CHOICE	EE Only	\$996.00	\$947.00	\$473.50	\$49.00	\$24.50
	EE + 1	\$2,036.00	\$1,761.00	\$880.50	\$275.00	\$137.50
	EE + 2 or more	\$2,781.00	\$2,339.00	\$1,169.50	\$442.00	\$221.00
	Overage Dep*	\$598.00	\$0.00	\$0.00	\$598.00	\$299.00
POS	EE Only	\$1,054.00	\$987.00	\$493.50	\$67.00	\$33.50
	EE + 1	\$2,123.00	\$1,795.00	\$897.50	\$328.00	\$164.00
	EE + 2 or more	\$2,904.00	\$2,403.00	\$1,201.50	\$501.00	\$250.50
	Overage Dep*	\$632.00	\$0.00	\$0.00	\$632.00	\$316.00

***Overage Dependent:** Additional amounts for each dep. age 26– 30 will be added to rates for other levels of coverage and 100%

Please visit the PBCBOCC website at <https://exploreuhcplans.com/pbcbocc> for more detailed information on plan benefits, medications covered, provider search tools for all networks and many videos on a variety of Healthier living resources.

To look up Behavioral Health providers, please click the Behavioral Health provider tab on the “Search for a Provider” page.

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

UHC NHP NETWORK (HMO) MEDICAL PLAN HIGHLIGHTS:

In-network benefits only – if you use doctors or hospitals that are out-of-network, you will NOT be covered for services, except for emergency care.

- “NHP HMO/POS” is the network name for providers, please visit <https://exploreuhcplans.com/pbcbocc> to look up providers on the “HMO” plan.
- **Requires selection of a Primary Care Physician**
- Primary care physician selected may be different for yourself and your dependents.
- **Requires referrals to receive in-network specialty care**
- Prior authorization is required for certain services and benefits to be covered (e.g. inpatient hospital services, outpatient facility services, advanced radiological imaging such as MRIs).
- Direct access (no referral required) for OB/GYN services, chiropractor or podiatrist, mental health and substance abuse care, and for a maximum of five (5) visits per contract year to dermatologist. Dermatology visits in addition to the five (5) mentioned before are subject to a referral from the primary care physician.
- Flex privileges: If you or one of your dependents will be residing temporarily in another location where there is a UHC HMO Network, you may be eligible for Managed Health Care Benefits at that location. Contact UHC customer service or the on-site UHC representative for more information.

UHC NATIONAL CHOICE OPEN ACCESS PLAN (CHOICE) MEDICAL PLAN HIGHLIGHTS:

In-network benefits only – if you use doctors or hospitals that are out-of-network, you will NOT be covered for services, except for emergency care.

- CHOICE provider network is a national network with providers in all 50 states.
- “CHOICE” is the network name for providers, please visit <https://exploreuhcplans.com/pbcbocc> to look up providers on the “CHOICE” plan.
- Designation of a Primary Care Physician is encouraged, but not required.
- Does not require referrals for specialty care (has to be an in-network Specialist).
- Prior authorization is required for certain services and benefits to be covered (e.g. inpatient hospital services, outpatient facility services, advanced radiological imaging such as MRIs).

UHC NHP NETWORK (POS) MEDICAL PLAN HIGHLIGHTS:

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



If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.



Meet Your Onsite Service Account Managers

Leslie Smalley and Evelyn Giraldo

Leslie and Evelyn are your onsite dedicated Service Account Managers. They are here to assist you with UHC support.

How can an Onsite Service Account Manager help me?

Leslie and Evelyn can help answer questions related to your UHC medical insurance such as:

- ✓ Claims issues
- ✓ Finding a doctor
- ✓ Help with mobile and online tools
- ✓ Billing issues
- ✓ Benefits coverage
- ✓ Pharmacy inquiries
- ✓ And much more



Telephone:
(561) 233-5463
Email:
Leslie_Smalley@uhc.com



Telephone:
(561) 233-5474
Email:
Evelyn_Giraldo@uhc.com



Will my personal information that I share with my Onsite Service Account Manager be protected?

None of your personal information will be shared with your employer. All personal health information will be protected in accordance with HIPAA.

Onsite Service Account Managers

Office Location: 100
Australian Ave #200, West
Palm Beach, FL, 33406

Hours of Operation:
Mon-Fri, 8:00 AM-5:00 PM



Pre-member Website:
exploreuhcplans.com/pbcbocc

MEDICAL PLAN HIGHLIGHTS (LIMITED)

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Annual deductibles and maximums	In-network Only	In-network Only	In-network	Out-of-network
Plan year deductible	Employee \$0.00 Employee & Family \$0.00	Employee \$0.00 Employee & Family \$0.00	Employee \$0.00 Employee & Family \$0.00	Per Individual \$500
Pre-existing Condition Limitation	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Plan year out-of-pocket maximum	Employee \$2,500 Employee & Family \$5,000	Employee \$2,500 Employee & Family \$5,000	Employee \$2,500 Employee & Family \$5,000	Employee \$3,000 Employee & Family \$6,000
Pharmacy out-of-pocket maximum	Employee \$3,850 Employee & Family \$7,700	Employee \$3,850 Employee & Family \$7,700	Employee \$3,850 Employee & Family \$7,700	
Physician services				
Office visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	You pay 30% Plan pays 70% after the deductible is met
Preventive care				
Routine preventive care	No charge	No charge	No charge	Out-of-network preventive care including immunizations for children through age 16 are covered at plan coinsurance with no deductibles.
Preventive Mammogram, PSA, Pap Smear	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Annual deductibles and maximums	In-network Only	In-network Only	In-network	Out-of-network
Lab and X-ray				
Lab and X-ray	No charge	Physician's Office – Primary Care Physician, you pay \$20 per visit Specialist, you pay \$40 per visit Independent Lab, Outpatient Facility – No charge *Radiology not applicable at Independent Lab	No charge	You pay 30% Plan pays 70% after the deductible is met
Advanced radiological imaging MRI, MRA, CT Scan, PET Scan, etc. Inpatient facility	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Advanced radiological imaging MRI, MRA, CT Scan, PET Scan, etc. Emergency Room/Urgent Care Facility	No charge	No charge	No charge	No charge
Advanced radiological imaging MRI, MRA, CT Scan, PET Scan, etc. Outpatient facility Physician's office	You pay a per scan copay of \$150, then no charge	You pay a per scan copay of \$150, then no charge	You pay a per scan copay of \$150, then no charge	You pay 30% Plan pays 70% after the deductible is met
Emergency and urgent care services				
Hospital emergency room	No charge after \$200 per visit copay	No charge after \$200 per visit copay	No charge after \$200 per visit copay	
Inpatient Professional Services	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Urgent care services Please note urgent care CANNOT give a referral for an MRI, for advanced radiology imaging services or for specialists	No charge after \$25 per visit copay	No charge after \$25 per visit copay	No charge after \$25 per visit copay	
Convenience Care Centers	You pay \$20 per visit	You pay \$20 per visit	You pay \$20 per visit	You pay 30% Plan pays 70% after the deductible is met

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Annual deductibles and maximums	In-network Only	In-network Only	In-network	Out-of-network
UHC Telehealth Services	No charge. Telehealth connects you with quality care without needing to go to your doctor or health care provider's office. Sign in to myuhc.com® to access your health plan account and view the most up-to-date list of your plan's network providers. Telehealth may be a great way to stay on top of your health from the comfort of your home.			
	Inpatient hospital facility services			
Semi-private room and board and other non-physician services	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
Inpatient Professional Services	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Outpatient Services				
Outpatient surgery (facility charges)	\$150 copay per visit, then Plan pays 100%	\$150 copay per visit, then Plan pays 100%	\$150 copay per visit, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met
Physical, occupational, cognitive and speech therapy	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
Maternity Care Services				
Physician's office – Initial Visit to confirm pregnancy	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	You pay 30% Plan pays 70% after the deductible is met
Physician's office –Subsequent prenatal visits, postnatal visits, and physician's delivery charges (i.e. global maternity fee)	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Delivery – Facility (inpatient Hospital, Birthing Center)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
UHC Telehealth Services	No charge. Telehealth connects you with quality care without needing to go to your doctor or health care provider's office. Sign in to myuhc.com® to access your health plan account and view the most up-to-date list of your plan's network providers. Telehealth may be a great way to stay on top of your health from the comfort of your home.			
	Inpatient hospital facility services			

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Annual deductibles and maximums	In-network Only	In-network Only	In-network	Out-of-network
Semi-private room and board and other non-physician services	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
Inpatient Professional Services	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Outpatient Services				
Outpatient surgery (facility charges)	\$150 copay per visit, then Plan pays 100%	\$150 copay per visit, then Plan pays 100%	\$150 copay per visit, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met
Physical, occupational, cognitive and speech therapy	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
Maternity Care Services				
Physician's office – Initial Visit to confirm pregnancy	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialist You pay \$40 per visit	You pay 30% Plan pays 70% after the deductible is met
Physician's office –Subsequent prenatal visits, postnatal visits, and physician's delivery charges (i.e. global maternity fee)	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Delivery – Facility (inpatient Hospital, Birthing Center)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
Special Services				
Skilled nursing facility, rehabilitation hospital and other facilities	No charge	No charge	No charge	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Annual deductibles and maximums	In-network Only	In-network Only	In-network	Out-of-network
Home health care	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Hospice	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
Durable medical equipment	No charge	No charge	No charge	\$200 Deductible then No charge
External prosthetic appliances (EPA)	No charge	No charge	No charge	You pay 30% Plan pays 70%
Mental health and substance abuse services				
Inpatient physician's office services	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then you pay 30% Plan pays 70% after the deductible is met
Outpatient physician's office services Unlimited	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
UHC Pharmacy three-tier copay plan Note: Certain categories of drugs and other products are included in the preventive care services coverage. The coverage emphasizes the prevention of disease and meeting the unique health care needs of women. For a list of specific products and prescriptions medications (as well as specific over-the-counter medications) which will be available at no cost, please review the information at myUHC.com or contact UHC for more information.	Retail (30 day supply) You pay: Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70 Home Delivery (90 day supply) You pay: Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140	Retail (30 day supply) You pay: Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70 Home Delivery (90 day supply) You pay: Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140	Retail (30 day supply) You pay: Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70 Home Delivery (90 day supply) You pay: Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140	Retail (30 day supply) You pay 30% Plan pays 70% Home Delivery Not covered

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Annual deductibles and maximums	In-network Only	In-network Only	In-network	Out-of-network
Pharmacy out-of-pocket maximum Retail and	Employee \$3,850 Employee & Family \$7,700	Employee \$3,850 Employee & Family \$7,700	Employee \$3,850 Employee & Family \$7,700	Employee \$3,850 Employee & Family \$7,700
Prescription smoking cessation drugs & OTC with a prescription	Covered - no copay applied	Covered - no copay applied	Covered - no copay applied	Covered - no copay applied
Physical, occupational, cognitive and speech therapy	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
Note: The UHC Prescription Drug List is available on myUHC.com to help you determine the cost of your prescribed medication.				

MEDICAL BENEFIT EXCLUSIONS

Medical Benefit Exclusions (by way of example but not limited to): Your plan provides coverage for medically necessary services.

Your plan does not provide coverage for the following except as required by law:

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Health plan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies;" or the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies."
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Rhinoplasty; Blepharoplasty; Orthognathic surgeries, except when Medically Necessary; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.

- Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
 - Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
 - Court ordered treatment or hospitalization, unless such treatment, is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
 - Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
 - Reversal of male and female voluntary sterilization procedures.
 - Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
 - Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of Massage Therapy

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



Digital tools to help you get the most out of your health plan benefits



Avery makes it easier to navigate your benefits

Your personalized digital tools – the UnitedHealthcare® app and **myuhc.com**® – give you access to resources integrated with Avery, a digital resource for your health plan. Avery is an always-on intelligent assistant to help you maximize your benefits and provide quick answers – making it easier to find what you're looking for and take action.

- Review plan documents, like Explanation of Benefits and Health Statements
- Find quality network providers with Smart Choice search results, personalized to your preferences
- View and pay claims, understand your account balances and deductibles
- See your health plan ID card and add your plan details to your smartphone's digital wallet
- Understand cost estimates or average cost data and covered services before you get care
- Discover additional benefits to support your health and well-being available through your health plan
- Learn more about the programs and benefits that are available to you

Register once to access both tools

Start by opening the UnitedHealthcare app or going to **myuhc.com** and then:

- Tap **Create account** on the app, or select **Register Now** on the website
- To create your account, fill in the required fields and follow the **protect your account** steps
- Enter your identification number, create password and agree to the terms and conditions

Now that you're registered, you'll be able to manage your plan all year long.

Get connected



Scan this code to download the UnitedHealthcare app or visit **myuhc.com** and get started with Avery

United
Healthcare®



Additional savings for employees

With a UnitedHealthcare dental or vision plan, employees have access to our Discount and Reward Marketplace powered by BenefitHub providing discount offers on services and products.

Valued savings from leading brands

Employees can access 200+ discounts on items and services such as:



Contact lenses – 10% savings on a range of leading brands



Online coaching – Discounts on programs for weight loss, stress reduction, diabetes management, smoking cessation and more



Lasik vision correction – Up to 35% savings through QualSight® LASIK, the nation's largest network of Lasik surgeons*



Health clubs – Savings on enrollment and monthly fees as well as personal training



Hearing aids – Up to 80% savings on advanced-technology hearing aids



Technology services, family entertainment, restaurants – Savings on a variety of ways to connect with friends and family

Learn more

Contact your UnitedHealthcare representative
or visit uhc.com/benefitHub

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* As of April 8, 2021.

The BenefitHub Discount Program is NOT insurance. The discount program provides discounts with certain retail participants. The discount program does not make payments directly to the retailers. The discount program member is obligated to pay for all services or products but will receive a discount from those retail participants who have contracted with the discount plan organization.



Compare options, help keep costs down

Getting care at the place that may best fit your condition or situation may save you up to \$250 or more compared to an emergency room (ER) visit.*

Care options to consider	START HERE				
	 Primary care provider (PCP) The provider who may know you best	 24/7 Virtual Visits A care provider over the phone, video or chat	 Convenience care Nurse practitioners and physician assistants at retail pharmacy clinics	 Urgent care Physicians and care teams at walk-in clinics	 Emergency room Physicians and care teams at hospital emergency departments
Approximate cost*	In-person: \$160 Virtual: \$99 or less**	\$0	\$25	\$25	\$250
Allergies	✓	✓			
Bladder infection/UTI	✓	✓		✓	
Broken bone				✓	✓
Bronchitis	✓	✓		✓	
Chest pain					✓
Cough	✓	✓	✓		
COVID-19 symptoms	✓	✓		✓	
Earache	✓	✓	✓		
Fever	✓	✓			
Flu/common cold	✓	✓	✓		
Migraine/headache	✓	✓			
Muscle ache/sprain	✓			✓	
Pinkeye	✓	✓			
Shortness of breath					✓
Sinus infection	✓	✓			
Skin rash	✓	✓	✓		
Sore throat	✓	✓			
Stomach pain (nausea, vomiting, diarrhea)	✓	✓		✓	
Yeast infection	✓	✓			

✓ Indicates the care option to consider for the common conditions listed

Learn more

Visit uhc.com/quickcare

United
Healthcare®

Let Optum Home Delivery bring your medications to you

With Optum® Home Delivery, you can get a 3-month supply of your long-term medications. Plus, they are mailed to you with free standard shipping.

Want more reasons?



Skip the trips

Your medications can be delivered to your door. You don't even have to leave home or wait in the pharmacy line.



Save some money

You may pay less than what you do at in-store pharmacies. And, standard shipping is free.



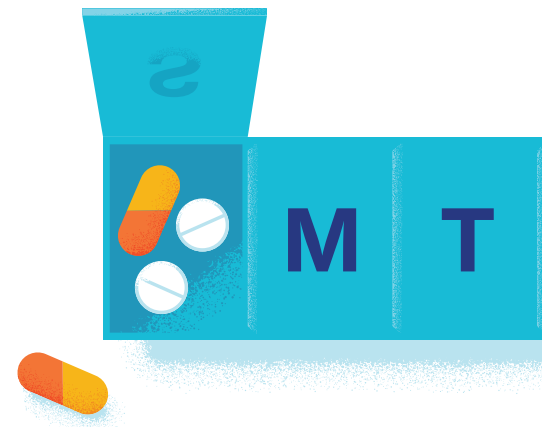
Stay on track

With a 3-month supply, you may be less likely to miss a dose. You can even sign up for automatic refills.



Pay your way

Make 1 payment upfront or split it up into 3 equal monthly payments with the Easy Payment Plan.



Get the lowest price

Members who use home delivery save \$10-12* on average per order when they use the drug pricing tool and fill with home delivery.

Go online or use the UnitedHealthcare app to see what you can save.

*2020 Optum Rx drug pricing tool cost analysis.

We're here when you need us

Use the website and app any time to track orders, request refills, price medications and more. Pharmacists and customer support team are also ready 24/7.

Ready for home delivery? Here are the ways to sign up.

- myuhc.com® or with the **UnitedHealthcare**® app.
- Or, ask your doctor to send an electronic prescription to Optum Rx.
- Or, call the number on your member ID card.



Frequently asked questions

Is Optum Home Delivery in my plan's network?

Yes, it's part of your plan's pharmacy network.

Once I've enrolled in home delivery, how long will it take to get my medication(s)?

Medications should arrive 2-5 business days after the pharmacy receives completed new and refill orders.

Do I need to set up a home delivery account?

Yes. Before we can ship your first order, you need to set up your UnitedHealthcare account and provide your payment method (credit card, debit card or bank account). Using your account, you can go online or use the app any time to place and track orders, check prices, and more.

What is a long-term medication?

Long-term medications are those you take on a regular basis. They may also be called "maintenance medications." These may be taken for high blood pressure, cholesterol and depression, just to name a few.

Can I use home delivery for any medication?

Many drugs are available through home delivery. See which of your prescriptions can be filled through home delivery by going online or using the app.

What is electronic prescription?

It's a way for your provider to send electronic prescriptions to Optum Rx. It is much faster than mailing and faxing prescriptions. Controlled substances can only be ordered by ePrescribe. Some exceptions apply.

Can I set up medication reminders?

Yes. Go online or use the app to check your profile and turn on email and phone notifications and reminders.

How does the automatic refill program work?

Go online or use the app to see and enroll eligible medications. Then, Optum Home Delivery will send your refills when it's time. They will notify you before they ship and they'll use your approved payment method on file. It's that easy.

How does the Easy Payment Plan work?

Call the number on the back of your member ID card to place your medication order and ask for the Easy Payment Plan. We'll split the cost for that order into 3 equal monthly payments that will be charged automatically to the payment method on file. When you make the first payment, we'll ship the entire supply. Then, we'll remind you before the other payments are due.

Don't wait.

Sign up for home delivery today.

Log in to myuhc.com or use the **UnitedHealthcare® app**.

Or, call the number on the back of your ID card.

Confused about health care terms? Visit justplainclear.com.





Welcome to the UnitedHealthcare specialty pharmacy program

Specialty medications are important to maintain or improve your health. Our specialty pharmacy program has resources and personalized support to help you with your condition.



What is a specialty medication?

An injected, infused, oral or inhaled medication is defined as a specialty medication if it:

- May need ongoing clinical oversight and extra education
- Has unique storage or shipping needs
- May not be available at retail pharmacies
- May need infusion or home nursing

What services does the specialty pharmacy provide?

UnitedHealthcare® offers specialty medication services through Optum® Specialty Pharmacy. Optum Specialty Pharmacy supports you with a team of pharmacists and nurses who specialize in your condition—at no extra cost to you. You also have:

- Access to your medications at your plan's lowest cost
- 24/7 access to pharmacists
- Clinical and adherence programs
- Medication supplies at no extra cost
- Refill reminders
- Timely delivery in confidential packaging

**United
Healthcare**

For more details in this benefits guide and the official plan documents, the language in the official plan documents shall

Guiding your health journey under the pharmacy benefit

We understand the challenge of living with and managing a complex health condition. Our specialty pharmacy program is here to assist you every step of the way.



Getting started

Call **1-855-427-4682** to enroll in the specialty pharmacy program.

Pharmacists and patient care coordinators are ready 24/7 to take care of everything, including:

- Transferring your prescription
- Helping find affordable ways to get your medication
- Explaining how to use the specialty pharmacy



Personalized support

Optum Specialty Pharmacy is always available by phone to answer any questions you may have about your medication, side effects and more. The personalized support doesn't stop there.

Virtual visits let you connect face-to-face with your care team. Ask for a real-time video chat with an expert in your condition. Your personal, confidential appointment gives you as much time as you need to ask questions from the privacy of your home. You can even record your session to review later or to share with your caregivers.

Video series can help you feel more connected to others with the same condition and give you a chance to learn more about your treatment. Hear from other patients with your condition about their treatment and how they are doing on it. Video libraries are currently only available for select conditions.



Working with your pharmacist or nurse

Tell your pharmacist or nurse about any changes or complications in your therapy, such as:

- Side effects
- Forgetting to take your medication

If you need help with any other health concerns, your pharmacist or nurse can help you find wellness management programs to help you stay on track.



Staying on track

Quick and easy refills

A few days before your next fill, we'll send you a refill reminder by email, phone or text. If you aren't already signed up for text messages, you can sign up by phone.

Fast, safe delivery

With Optum Specialty Pharmacy, shipping your medication is quick, easy and safe. Refrigerated medications will be shipped overnight to the address you choose in a temperature-controlled package. Others will be shipped within 1–3 days. Supplies will also be sent at no extra cost.

Save more money

Optum Specialty Pharmacy can only fill your specialty medications. Use your home delivery or retail pharmacy for your non-specialty prescriptions.

If you're looking to save money on your medications, finding lower-cost options and filling your non-specialty prescriptions by mail can help.



Got your ID card? Let's get started

If you have your health plan ID card, you're ready to get started. While managing a health plan can be confusing, here's where it gets easier. Use this checklist to help take charge of your health — and get more out of your plan. Here's how to get started.



Check out myuhc.com®

Log in and use this personalized website to access and manage your health plan details. It's got helpful tools to help you:

- Find and estimate costs for the network care you need
- See what's covered and get information about preventive care
- View claim details and account balances
- Sign up for paperless delivery of your required plan communications



Get on-the-go access

When you're out and about, the UnitedHealthcare mobile app puts your health plan at your fingertips. Download it for free to easily access your ID card, find nearby care, check medical balances, claims, and more.



Know your network and get engaged

With almost every plan, you'll pay less if you choose doctors, clinics and hospitals in your network. It's easy to check who's in the network by using the provider directory on **myuhc.com** or the UHC apps.



Save the Advocate4Me® phone number.

Call or chat with an Advocate about an illness, injury and more. Save the number 1-833-992-0878 to your phone, post it on your fridge or anywhere that's convenient for you.



Check out your pharmacy benefits.

OptumRx® is our pharmacy care services manager. Here are cost-effective ways to get your medications within your pharmacy network:

- Visit myuhc.com to see drug costs and coverage. Use our online drug pricing tool or the UHC app to search for lower-cost alternatives.
- Review your Prescription Drug List (PDL).
 - Take note of which medications are covered by your plan.
 - Ask your doctor about trying less expensive medications if you have concerns about the cost of your medications.
 - Check to see if any of your medications have additional requirements, like prior authorizations or step therapy.
- Consider using home delivery for maintenance medications — those you take regularly — to save time. You may even pay less.



Get to know your UHC Support Team

Onsite Health Care Advocates:

Evelyn Giraldo 561-233-5474

Evelyn_Giraldo@uhc.com

Leslie Smalley 561-233-5463

Leslie_Smalley@uhc.com



See a doctor whenever, wherever

When you're sick and need care quick, a **24/7 Virtual Visit** is a convenient way to start feeling better faster. See and talk to a doctor via mobile device or computer -24/7, no appointment needed. Access a 24/7 Virtual Visit via the UHC App or **myuhc.com**.

Learn more

Find more resources at exploreuhcplans.com/pbcbooc, including short videos about starting your plan, using your benefits and managing costs.

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Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the Health Survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

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

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

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If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.



Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal® powered by Wellos®, an online weight management support program.



Support for a healthier lifestyle, at no additional cost to you

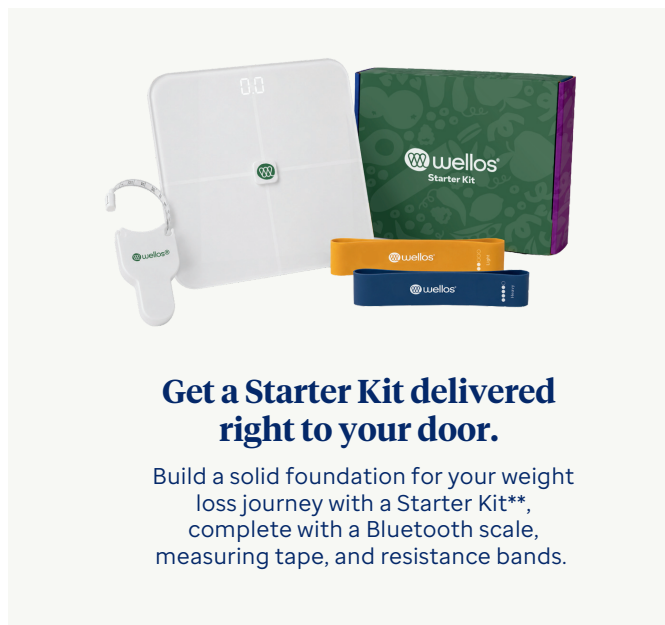
Real Appeal – now powered by Wellos technology – is a evidence-based weight management program designed to help you get healthier and stay healthier. It's available to you at **no additional cost** as part of your benefits.*

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that may keep you motivated to create lasting change. Track your progress right in the Wellos app.

Support and community along the way

Supported with personalized messages, online group sessions led by coaches and a caring community of members.



Get a Starter Kit delivered right to your door.

Build a solid foundation for your weight loss journey with a Starter Kit**, complete with a Bluetooth scale, measuring tape, and resistance bands.



Join today at
uhc.realappeal.com
or scan this code

United
Healthcare®

Real Appeal® powered by
wellos

*Real Appeal® powered by Wellos® is available to individuals who are eligible through their health benefits and meet certain biometric criteria. Coaches cannot diagnose or recommend treatment. It is not appropriate for emergency care; call 911 or visit the ER. If you are already under a provider's care or taking prescription medication, consult your provider before enrolling. Results may vary. The program is not configured for individuals who are pregnant, breastfeeding, or diagnosed with an eating disorder.

**The Starter Kit is available to first-time enrollees after attending their first session. Items may be taxable. Consult an appropriate tax professional to determine tax obligations.

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

Real Appeal is a registered trademark of Real Appeal, LLC. Wellos and the Wellos logo(s) are trademarks of RVO Health, LLC. All other trademarks are the property of their respective owners.

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.



Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video¹ through **myuhc.com**[®] or the UnitedHealthcare[®] app.



A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,² if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually \$0.³**

Consider 24/7 Virtual Visits for these common conditions:

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

\$0

cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit — bringing a potential \$2,000⁴ cost down to \$0.

Get started

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

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¹ Data rates may apply.

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

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

⁴ Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on the difference between average Urgent Care visit cost of \$180 and Virtual Visit cost of \$0; \$2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

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

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

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

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A wellness program built for *real life*.

Make sustainable changes
at your own pace.

Start your Wellos journey today.

Tracking that teaches.

Embrace personalized
Insights Reports based
on your real-life data.



Coaching that comes to you.

Talk live with an expert
coach who cares about
your success.



Personalized support.

Energize your routine with
content and challenges
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VISION BENEFITS

UNITEDHEALTHCARE



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

UHC Vision Plan Highlights: The summary below lists vision care benefits that are available to participants in the UHC medical plans through UHC Vision. For additional information and provider lists, call UHC Vision at 833-760-7892 or visit myUHC.com

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

+ Option also applies to Domestic Partners and/or Children of Domestic Partners and eligible dependents.

* DeltaCare USA DHMO plans are not available outside of Florida.

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

FLORIDA KIDCARE



LILIANA
Tampa, FL

FAVORITE HOBBY:
Reading at the library

FAVORITE SNACK:
Sliced watermelon

FAVORITE FLORIDA KIDCARE PERK:
The bookmark she gets after her vision screening

Florida KidCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call 1-888-540-5437
(TTY: 1-800-955-8771).

Florida KidCare cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-888-540-5437
(TTY: 1-800-955-8771).

Florida KidCare konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-888-540-5437
(TTY: 1-800-955-8771).

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HEALTH AND DENTAL INSURANCE

HOW TO APPLY

floridakidcare.org • 1-888-540-KIDS (5437)

2019

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KidCare
HEALTH AND DENTAL INSURANCE



**HEAD-TO-TOE
HEALTH COVERAGE
FOR KIDS**

DENTAL BENEFITS

UNITED HEALTHCARE



- \$1,000 in-network calendar year max / \$500 out-of-network calendar year maximum
- Deductible (Applies to all services, including preventive both in and out of network)
 - In-Network - \$50 individual/\$100 family
 - Out-of-Network - \$100 individual/\$300 family

Plan coverage

- **In-Network**
 - 100% preventive (Standard dental cleaning (Code 1110) - 2 per 12 consecutive months)
 - 70% restorative (fillings/simple extractions)
 - 40% major (crowns/specialty services (Endo/Perio/OS)
- **Out-of-Network**
 - 80% preventive (Standard dental cleaning (Code 1110) - 2 per 12 consecutive months)
 - 50% restorative (fillings/simple extractions)
 - 20% major (crowns/specialty services (Endo/Perio/OS)
- Ortho covered up to the age of 19 years with \$1,000 lifetime maximum both in and out of network (Plan coverage 50% up to the \$1,000 lifetime maximum in and out of network)
- Claims paid out of network based on in-network contracted provider's fees
- No Implant coverage

PPO High

- \$1,500 in-network calendar year max / \$1,000 out-of-network calendar year max
- Deductible (Applies to restorative and major services only, not for preventive both in and out of network)
- In-Network - \$50 individual/\$100 family | Out-of-Network - \$100 individual/\$300 family

Plan coverage

- **In-Network**
 - 100% preventive (Standard dental cleaning (Code 1110) - 2 per 12 consecutive months)
 - 80% restorative (fillings/simple extractions)
 - 50% major (crowns/specialty services (Endo/Perio/OS))
- **Out-of-Network**
 - 90% preventive (Standard dental cleaning (Code 1110) - 2 per 12 consecutive months)
 - 70% restorative (fillings/simple extractions)
 - 40% major (crowns/specialty services (Endo/Perio/OS))
- Ortho covered both adults and children with \$1,000 lifetime maximum both in and out of network (Plan coverage 50% up to the \$1,000 lifetime maximum in and out of network)
- Claims paid out of network based 80% of usual and customary charge
- Implant coverage – Separate \$2,500 maximum both in and out of network
- Anesthesia – Covered when medically necessary or when administered in conjunction with approved extractions impactions (Codes: 7230/7240/7241) of a 3rd molar. Recommend claim submitted for predetermination prior to services being rendered.

PPO Premier

- \$3,500 calendar year max both in and out of network
- Deductible (Applies to restorative and major services only, not for preventive both in and out of network)
- In-Network and Out-of-Network - \$50 individual/\$150 family

Plan coverage

- **In-Network**
 - 100% preventive (Standard dental cleaning (Code 1110) - 2 per 12 consecutive months)
 - 80% restorative (fillings/simple extractions)
 - 50% major (crowns/specialty services (Endo/Perio/OS))
- **Out-of-Network**
 - 90% preventive (Standard dental cleaning (Code 1110) - 2 per 12 consecutive months)
 - 70% restorative (fillings/simple extractions)
 - 40% major (crowns/specialty services (Endo/Perio/OS))
- Ortho covered both adults and children with \$2,000 lifetime maximum both in and out of network (Plan coverage 50% up to the \$2,000 lifetime maximum in and out of network)
- Claims paid out of network based 90% of usual and customary charge
- Implant coverage – Separate \$2,500 maximum both in and out of network
- Anesthesia – Covered when medically necessary or when administered in conjunction with approved extractions impactions (Codes: 7230/7240/7241) of a 3rd molar. Recommend claim submitted for predetermination prior to services being rendered.

DHMO Basic Access+

- No calendar year maximum or deductible
- Covered procedures listed on the Member fee schedule – Members know what their responsibility is as all covered ADA codes are listed on the DHMO schedule of benefits (over 500 covered ADA codes)
- Standard dental cleaning (Code 1110) covered once every 6 months – Note additional cleanings are covered at a member co-payment
- No dental office rosters or waiting periods
- No primary dentist selection necessary
- Open Access Network – As long as a member is treated by an in-network provider, they do not have to select a primary care dentist. Family members may use different dentists. This applies to all ADA codes other than the 35 Codes out of network covered codes.
- 35 ADA codes covered out of network – These codes are listed on the member fee schedule. All other ADA codes member must use an in-network

DHMO Enhanced Access +

- Includes everything in Basic Access+
- Member copayments are lower than the basic DHMO plan by 15%
- Anesthesia – Covered when medically necessary or when administered in conjunction with approved extractions impactions (Codes: 7230/7240/7241) of a 3rd molar.

Scan the QR code for full plan summaries



DHMO Basic S700B Access+



DHMO Enhanced S200B Access+

Dental Insurance – UnitedHealthcare – Premiums are 100% employee paid

Plans	Basic DHMO	Low PPO	High PPO	Enhanced DHMO	Premier PPO
Level of Coverage	Monthly Cost/ Biweekly Ded	Monthly Cost/ Biweekly Ded	Monthly Cost/ Biweekly Ded	Monthly Cost/ Biweekly Ded	Monthly Cost/ Biweekly Ded
EE Only	\$12.18 mo / \$6.09 biwkly	\$19.50 mo / \$9.75 biwkly	\$38.16 mo / \$19.08 biwkly	\$15.62 mo / \$7.81 biwkly	\$47.26 mo / \$23.63 biwkly
EE + 1	\$20.82 mo / \$10.41 biwkly	\$37.02 mo / \$18.51 biwkly	\$73.14 mo / \$36.57 biwkly	\$27.34 mo / \$13.67 biwkly	\$90.60 mo / \$45.30 biwkly
EE + 2	\$28.20 mo / \$14.10 biwkly	\$45.30 mo / \$22.65 biwkly	\$84.48 mo / \$42.24 biwkly	\$33.86 mo / \$16.93 biwkly	\$104.66 mo / \$52.33 biwkly
EE + 3 or more	\$37.22 mo / \$18.61 biwkly	\$62.88 mo / \$31.44 biwkly	\$119.50 mo / \$59.75 biwkly	\$43.00 mo / \$21.50 biwkly	\$148.02 mo / \$74.01 biwkly

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

 UnitedHealthcare Insurance Company		LOW PPO		Dental Plan New Standard/021P1/MAC	
		NON-ORTHODONTICS		ORTHODONTICS	
		NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible		\$50	\$100	\$0	\$0
Family Annual Deductible		\$150	\$300	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)		\$1,000 per person per Calendar Year	\$500 per person per Calendar Year	\$1,000 per person per Lifetime	\$1,000 per person per Lifetime
New enrollee's waiting period		None			
Annual deductible applies to preventive and diagnostic services				Yes (In Network)	Yes (Out Network)
Annual Deductible Applies to Orthodontic Services				No	
Orthodontic Eligibility Requirement				Child Only (Up to Age 19)	
CMM-Annual Roll-Over				Yes	
COVERED SERVICES *		NETWORK PLAN PAYS**		NON-NETWORK PLAN PAYS***	
DIAGNOSTIC SERVICES				BENEFIT GUIDELINES	
Periodic Oral Evaluation		100%	80%	See Exclusions and Limitations section for benefit guidelines.	
Radiographs		100%	80%		
Lab and Other Diagnostic Tests		100%	80%		
PREVENTIVE SERVICES				See Exclusions and Limitations section for benefit guidelines.	
Prophylaxis (Cleaning)		100%	80%		
Fluoride Treatment (Preventive)		100%	80%		
Sealants		100%	80%		
Space Maintainers		100%	80%		
BASIC SERVICES				See Exclusions and Limitations section for benefit guidelines.	
Restorations (Amalgams or Composite)		70%	50%		
Emergency Treatment/General Services		70%	50%		
General Services - Adjunctive Occlusal Guard		70%	50%		
General Services - Adjunctive Emergency Treatment		70%	50%		
General Services - Adjunctive Other		70%	50%		
Simple Extractions		70%	50%	Emergency Treatment and General Services that fall under Restorations, Amalgams or Composites will be covered at this benefit level.	
MAJOR SERVICES					
Emergency Treatment/General Services		40%	20%		
General Services - Adjunctive Anesthesia		40%	20%		
Oral Surgery (incl. surgical extractions)		40%	20%		
Periodontics		40%	20%		
Endodontics		40%	20%		
Inlays/Onlays/Crowns		40%	20%		
Dentures and Removable Prosthetics		40%	20%		
Fixed Partial Dentures (Bridges)		40%	20%		
ORTHODONTIC SERVICES					
Diagnose or correct misalignment of the teeth or bite		50%	25%		

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

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

***The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- C. The least costly, clinically accepted treatment, and
- D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

- 1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.
- 2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.
- 3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.
- 4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
- 5 DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.
- 6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
- 7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
- 8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
- 9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
- 10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
- 11 INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 13 POST AND CORES Covered only for teeth that have had root canal therapy.
- 14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
- 15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.
- 16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
- 17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
- 18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
- 21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
- 22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
- 23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
- 24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
- 25 GENERAL ANESTHESIA Covered only when clinically necessary.
- 26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
- 27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
- 28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- 29 CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

The following are not covered:

- 1 Dental Services that are not Necessary.
- 2 Hospitalization or other facility charges.
- 3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- 4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- 5 Any Dental Procedure not directly associated with dental disease.
- 6 Any Dental Procedure not performed in a dental setting.
- 7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- 8 Placement of dental implants, implant-supported abutments and prostheses.
- 9 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 10 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- 11 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- 12 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- 13 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- 14 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- 15 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- 16 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- 17 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- 18 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 19 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- 20 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 21 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situated in the state of Arizona, in order to comply with state regulations.
- 22 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- 23 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- 24 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
- 25 Foreign Services are not Covered unless required as an Emergency.
- 26 Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- 27 Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.



Included with the Low PPO Dental Plan

Dental | Consumer MaxMultiplier

Get rewarded for taking care of your smile



Our Consumer MaxMultiplier® program rewards you for keeping up with your dental care by adding dollars to next year's annual maximum. It's included as part of your dental plan.

How the program works



Earn award dollars for visiting your dentist at least once a year.¹



Your award dollars will help to pay for claims that go beyond your annual maximum.



Unused award dollars can roll over each year.

Earn up to

\$225

to add to your 500 annual maximum

Award dollars can add up

Here's an example of the award dollars you could earn if you visit your dentist at least once this year:

This year's annual maximum is
\$500

If your total claims are less than
\$250

You'll earn a reward of
\$125

Plus, if you have a Dental PPO plan and all claims are with network dentists, you'll earn an extra \$100. Your award dollars will be added to next year's annual maximum to pay for qualifying claims. To view your annual maximum balance, log in to myuhc.com®.

continued

**United
Healthcare**

Program rules

1. \$500 is the most award dollars that can be rolled over to the annual maximum. The total annual maximum cannot go above \$1,000.
2. If your plan has different annual network and out-of-network maximums, the award dollars will be based on the annual out-of-network maximum. Award dollars are added to your annual maximum the following year.
3. Award dollars can be used for claims filed up to 180 days after your benefit period ends.
4. Award dollars can be used for both network and out-of-network claims.
5. Award dollars do not apply to orthodontic services.
6. If you sign up for a UnitedHealthcare Dental PPO or Dental In-Network Only (INO) plan in the last 3 months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in this program.
7. If you end your coverage, but sign up again within 6 months with the same employer, you can keep your award balance as long as your employer still offers a dental plan with Consumer MaxMultiplier. If 6 months or more pass, you will lose the award balance.
8. If your employer decides to change your dental plan, your award balance will move with you as long as the new plan includes Consumer MaxMultiplier.

Questions?

Call the member phone number on your digital ID card

United
Healthcare

¹ You will not actually earn cash that you can access or withdraw. UnitedHealthcare adds the award dollars to your annual maximum for the following year and applies them to qualifying claims.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter.

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

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

This program may not be available in all states. Components subject to change.

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the company.

UnitedHealthcare dental coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), DBP Services (NY only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX, DPOL.12.TX and DPOL.12.TX (Rev. 9/16) and associated COC form numbers DCOC.CER.06, DCOC.CER.IND.12.TX and DCERT.IND.12.TX. Plans sold in Virginia use policy form number DPOL.06.VA with associated COC form number DCOC.CER.06.VA and policy form number DPOL.12.VA with associated COC form number DCOC.CER.12.VA.

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UHC Dental Market Solutions

2000003981 04/11/22

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

 UnitedHealthcare Insurance Company		HIGH PPO		Dental Plan	
				New Standard/021P2/U80	
		NON-ORTHODONTICS		ORTHODONTICS	
		NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible		\$50	\$100	\$0	\$0
Family Annual Deductible		\$150	\$300	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)		\$1,500 per person per Calendar Year	\$1,000 per person per Calendar Year	\$1,000 per person per Lifetime	\$1,000 per person per Lifetime
Implant Annual Maximum Benefit		\$2,500 per person per Calendar Year	\$2,500 per person per Calendar Year		
New enrollee's waiting period		None			
Annual deductible applies to preventive and diagnostic services				No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services				No	
Orthodontic Eligibility Requirement				Adult & Child	
CMM-Annual Roll-Over				Yes	
COVERED SERVICES *		NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
DIAGNOSTIC SERVICES					
Periodic Oral Evaluation		100%	90%	See Exclusions and Limitations section for benefit guidelines.	
Radiographs		100%	90%		
Lab and Other Diagnostic Tests		100%	90%		
PREVENTIVE SERVICES					
Prophylaxis (Cleaning)		100%	90%	See Exclusions and Limitations section for benefit guidelines.	
Fluoride Treatment (Preventive)		100%	90%		
Sealants		100%	90%		
Space Maintainers		100%	90%		
BASIC SERVICES					
Restorations (Amalgams or Composite)		80%	70%	See Exclusions and Limitations section for benefit guidelines.	
Emergency Treatment/General Services		80%	70%		
General Services - Adjunctive Occlusal Guard		80%	70%	Emergency Treatment and General Services that fall under Restorations, Amalgams or Composites will be covered at this benefit level.	
General Services - Adjunctive Emergency Treatment		80%	70%		
General Services - Adjunctive Other		80%	70%		
Simple Extractions		80%	70%		
MAJOR SERVICES					
Emergency Treatment/General Services		50%	40%	See Exclusions and Limitations section for benefit guidelines.	
General Services - Adjunctive Anesthesia		50%	40%		
Oral Surgery (incl. surgical extractions)		50%	40%	Emergency Treatment and General Services that fall under Oral Surgery, Periodontics, Endodontics, Crowns, Dentures and Dentures will be covered at this benefit level.	
Periodontics		50%	40%		
Endodontics		50%	40%		
Inlays/Onlays/Crowns		50%	40%		
Dentures and Removable Prosthetics		50%	40%		
Fixed Partial Dentures (Bridges)		50%	40%		
Implants		50%	40%		
ORTHODONTIC SERVICES					
Diagnose or correct misalignment of the teeth or bite		50%	50%		

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

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

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- C. The least costly, clinically accepted treatment, and
- D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

- 1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.
- 2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.
- 3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.
- 4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
- 5 DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.
- 6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
- 7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
- 8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
- 9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
- 10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
- 11 INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 13 POST AND CORES Covered only for teeth that have had root canal therapy.
- 14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
- 15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.
- 16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
- 17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
- 18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
- 21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
- 22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
- 23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
- 24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
- 25 GENERAL ANESTHESIA Covered only when clinically necessary.
- 26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
- 27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
- 28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- 29 CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

The following are not covered:

- 1 Dental Services that are not Necessary.
- 2 Hospitalization or other facility charges.
- 3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- 4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- 5 Any Dental Procedure not directly associated with dental disease.
- 6 Any Dental Procedure not performed in a dental setting.
- 7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- 8 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 9 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- 10 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- 11 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- 12 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- 13 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- 14 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- 15 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- 16 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- 17 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 18 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- 19 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 20 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situated in the state of Arizona, in order to comply with state regulations.
- 21 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- 22 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- 23 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
- 24 Foreign Services are not Covered unless required as an Emergency.
- 25 Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- 26 Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.



Included with the HIGH PPO

Dental | Consumer MaxMultiplier



Get rewarded for taking care of your smile

Our Consumer MaxMultiplier® program rewards you for keeping up with your dental care by adding dollars to next year's annual maximum. It's included as part of your dental plan.

How the program works



Earn award dollars for visiting your dentist at least once a year.¹



Your award dollars will help to pay for claims that go beyond your annual maximum.



Unused award dollars can roll over each year.

Earn up to

\$350

to add to your 1000 annual maximum

Award dollars can add up

Here's an example of the award dollars you could earn if you visit your dentist at least once this year:

This year's annual maximum is
\$1000

If your total claims are less than
\$500

You'll earn a reward of
\$250

Plus, if you have a Dental PPO plan and all claims are with network dentists, you'll earn an extra \$100. Your award dollars will be added to next year's annual maximum to pay for qualifying claims. To view your annual maximum balance, log in to myuhc.com®.

continued

United
Healthcare

Program rules

1. \$1,000 is the most award dollars that can be rolled over to the annual maximum. The total annual maximum cannot go above \$2,000.
2. If your plan has different annual network and out-of-network maximums, the award dollars will be based on the annual out-of-network maximum. Award dollars are added to your annual maximum the following year.
3. Award dollars can be used for claims filed up to 180 days after your benefit period ends.
4. Award dollars can be used for both network and out-of-network claims.
5. Award dollars do not apply to orthodontic services.
6. If you sign up for a UnitedHealthcare Dental PPO or Dental In-Network Only (INO) plan in the last 3 months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in this program.
7. If you end your coverage, but sign up again within 6 months with the same employer, you can keep your award balance as long as your employer still offers a dental plan with Consumer MaxMultiplier. If 6 months or more pass, you will lose the award balance.
8. If your employer decides to change your dental plan, your award balance will move with you as long as the new plan includes Consumer MaxMultiplier.

Questions?

Call the member phone number on your digital ID card

**United
Healthcare**

¹ You will not actually earn cash that you can access or withdraw. UnitedHealthcare adds the award dollars to your annual maximum for the following year and applies them to qualifying claims.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter.

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

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

This program may not be available in all states. Components subject to change.

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the company.

UnitedHealthcare dental coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), DBP Services (NY only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX, DPOL.12.TX and DPOL.12.TX (Rev. 9/16) and associated COC form numbers DCOC.CER.06, DCOC.CER.IND.12.TX and DCERT.IND.12.TX. Plans sold in Virginia use policy form number DPOL.06.VA with associated COC form number DCOC.CER.06.VA and policy form number DPOL.12.VA with associated COC form number DCOC.CER.12.VA.

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UHC Dental Market Solutions

2000003985 04/11/22

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UnitedHealthcare Insurance Company		PREMIER PPO		Dental Plan New Standard/020P9/U90	
		NON-ORTHODONTICS		ORTHODONTICS	
		NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible		\$50	\$50	\$0	\$0
Family Annual Deductible		\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)		\$3,500 per person per Calendar Year	\$3,500 per person per Calendar Year	\$2,000 per person per Lifetime	\$2,000 per person per Lifetime
Implant Annual Maximum Benefit		\$2,500 per person per Calendar Year	\$2,500 per person per Calendar Year		
New enrollee's waiting period		None			
Annual deductible applies to preventive and diagnostic services				No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services				No	
Orthodontic Eligibility Requirement				Adult & Child	
COVERED SERVICES *		NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
DIAGNOSTIC SERVICES					
Periodic Oral Evaluation		100%	90%	See Exclusions and Limitations section for benefit guidelines.	
Radiographs		100%	90%		
Lab and Other Diagnostic Tests		100%	90%		
PREVENTIVE SERVICES					
Prophylaxis (Cleaning)		100%	90%	See Exclusions and Limitations section for benefit guidelines.	
Fluoride Treatment (Preventive)		100%	90%		
Sealants		100%	90%		
Space Maintainers		100%	90%		
BASIC SERVICES					
Restorations, Amalgams or Composite (Anterior & Posterior)		80%	70%	See Exclusions and Limitations section for benefit guidelines.	
Emergency Treatment/General Services		80%	70%		
General Services - Adjunctive Occlusal Guard		80%	70%	Emergency Treatment and General Services that fall under Restorations, Amalgams or Composites will be covered at this benefit level.	
General Services - Adjunctive Emergency Treatment		80%	70%		
General Services - Adjunctive Other		80%	70%		
Simple Extractions		80%	70%		
MAJOR SERVICES					
Emergency Treatment/General Services		50%	40%	See Exclusions and Limitations section for benefit guidelines.	
General Services - Adjunctive Anesthesia		50%	40%		
Oral Surgery (incl. surgical extractions)		50%	40%	Emergency Treatment and General Services that fall under Oral Surgery, Periodontics, Endodontics, Crowns, Dentures and Dentures will be covered at this benefit level.	
Periodontics		50%	40%		
Endodontics		50%	40%		
Inlays/Onlays/Crowns		50%	40%		
Dentures and Removable Prosthetics		50%	40%		
Fixed Partial Dentures (Bridges)		50%	40%		
Implants		50%	40%		
ORTHODONTIC SERVICES					
Diagnose or correct misalignment of the teeth or bite		50%	50%		

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

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

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- C. The least costly, clinically accepted treatment, and
- D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

- 1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.
- 2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.
- 3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.
- 4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
- 5 DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.
- 6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
- 7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
- 8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
- 9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
- 10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
- 11 INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 13 POST AND CORES Covered only for teeth that have had root canal therapy.
- 14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
- 15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.
- 16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
- 17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
- 18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
- 21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
- 22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
- 23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
- 24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
- 25 GENERAL ANESTHESIA Covered only when clinically necessary.
- 26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
- 27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
- 28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- 29 CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

The following are not covered:

- 1 Dental Services that are not Necessary.
- 2 Hospitalization or other facility charges.
- 3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- 4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- 5 Any Dental Procedure not directly associated with dental disease.
- 6 Any Dental Procedure not performed in a dental setting.
- 7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- 8 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 9 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- 10 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- 11 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- 12 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- 13 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- 14 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- 15 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- 16 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- 17 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 18 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- 19 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 20 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situated in the state of Arizona, in order to comply with state regulations.
- 21 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- 22 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- 23 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
- 24 Foreign Services are not Covered unless required as an Emergency.
- 25 Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- 26 Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

Clear Vision 100 Discount Vision Plan

BENEFITS

Plan Highlights

- Members of the Clear Vision 100 Discount Plan are eligible to receive benefits immediately upon the effective date with unlimited benefits.
- The member fees listed are guaranteed to be a 20-40% discount and are offered by a participating Clear Vision product provider.
- This Plan is not insurance. This Plan provides discounts at certain providers for vision services. The plan does not make payments directly to the providers of the vision service. The member is obligated to pay for all vision care services but will receive a discount from those providers who have contracted with the discount plan organization.
- The patient/member is ultimately responsible for verification as to the accuracy and appropriateness of all applicable fees.
- Members can choose a participating Clear Vision provider at <https://exploreuhcplans.com/pbcbooc>
- Benefit for contacts or frames are a once a year benefit (e.g., if a member chooses frames one year, they can choose contacts the following year).

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

LIFE INSURANCE

SECURIAN



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

Important Life Insurance Beneficiary Information: Beginning January 1, 2027, life insurance beneficiaries are designated with and managed solely by Securian (the life insurance carrier). Review your existing beneficiary designation on file, or designate a beneficiary for the first time by visiting LifeBenefits.com. When a death claim is filed with Securian, the following steps will be followed for confirmation of beneficiaries on file:

1. Proceeds will be paid to beneficiaries named by the employee and on file with Securian.
2. If the employee does not have a named beneficiary on file with Securian, life insurance proceeds will be paid based on the beneficiary plan default as listed in The County's Term Life Policy with Securian (Policy 70953).
3. For more information, please see Securian's Beneficiary Designation FAQ's page in this Guidebook.



Palm Beach County
Group term life and accidental death and
dismemberment (AD&D) insurance

Insurance products issued by: Minnesota Life Insurance Company



Summary of life insurance coverage options and cost



Life insurance benefits through your employer can help your family navigate the financial challenges that may arise from the loss of a loved one.



Learn more

Visit Securian's educational microsite to learn more about your insurance program, naming beneficiaries, applying for coverage that requires health questions and much more.

Visit securian.com/pbc-insurance

Term life insurance provides a budget-friendly way to help protect your family's financial future.

- **Income replacement:** Can help your family maintain their lifestyle by covering essential daily living expenses like mortgage/rent payments, child care, groceries and more
- **Final expenses:** May ease the burden of funeral costs, medical bills and other end-of-life expenses
- **Cost-effective:** Employer-based life insurance is generally less expensive than other life insurance solutions. It can allow you to temporarily supplement your outside coverage, to increase your total protection during your working years when your family depends on your income

Accidental death and dismemberment (AD&D) insurance provides additional financial protection for a loss resulting from a covered accident – whether the accident occurs at work or elsewhere.

- **Accidental death:** Pays both life insurance and AD&D benefits to your beneficiary
- **Dismemberment:** Provides direct payments to you, based on the severity of the injury

Act now to protect your family through the unexpected.

Your basic and additional coverages

Basic coverages (automatic benefit)

Basic term life	\$25,000
Basic AD&D	\$15,000

Additional coverages (employee paid)

Additional term life and AD&D	\$10,000 increments	• Maximum: \$500,000 • Includes an AD&D benefit that matches the amount of term life insurance coverage
Spouse/domestic partner (DP) term life and AD&D	\$5,000 increments	• Maximum: \$100,000 • Coverage may not exceed 100% of the amount of the employee's term life amount • Includes an AD&D benefit that matches the amount of term life insurance coverage
Child term life	\$5,000 or \$10,000	• Children are eligible from live birth to age 26 • Coverage may not exceed 100% of the amount of the employee's term life amount

If your spouse/DP or child is eligible for coverage as an employee, they cannot be covered as your dependent. A child may be covered by only one employee.

Beginning at age 70, employee basic and additional term life coverage reduces to 50 percent.

Beneficiary

Your beneficiary(ies) will receive insurance proceeds in the event of your death. Keep this designation up to date as life progresses, to help ensure any payment would be made according to your wishes and without delay. You are the beneficiary of insurance on your dependents.

Beyond active employment

You can choose to continue to be insured with Securian Financial beyond active employment. Premiums are generally higher than those paid by active employees.

Coverage available without health questions

There are certain times in which you can enroll for coverage without answering health questions. Below is a summary of those options.

Within 31 days of initial eligibility

- Additional term life: Elect up to \$300,000
- Spouse/DP term life: Elect up to \$50,000

During each annual enrollment

- Additional term life: Elect \$10,000, or increase existing coverage by \$10,000; not to exceed a new total of \$300,000
- Spouse/DP term life: Elect \$5,000, or increase existing coverage by \$5,000; not to exceed a new total of \$50,000

Within 31 days of a qualified status change

- Additional term life: Increase existing coverage by one increment of \$10,000; not to exceed \$300,000

Health questions never required

- Child term life coverage can be elected during any enrollment period, and never requires health questions.

To apply for coverage other than what's outlined here, you'll be asked to satisfy an evidence of insurability application that generally consists of just a few health questions.

Once your coverage is effective, you never have to re-enroll to continue your coverage.

Enroll/update coverage

Access your group enrollment system, MyBenefits, to enroll

Questions?

Contact risk management/
group insurance:

561-233-5400 or email:

bccmybenefits@pbcgov.org

Bi-weekly cost of coverage**Additional term life and AD&D**

Coverage amount	Deduction
\$10,000	\$1.46
\$20,000	2.92
\$30,000	4.38
\$40,000	5.84
\$50,000	7.30
\$60,000	8.76
\$70,000	10.22
\$80,000	11.68
\$90,000	13.14
\$100,000	14.60
\$110,000	16.06
\$120,000	17.52
\$130,000	18.98
\$140,000	20.44
\$150,000	21.90
\$160,000	23.36
\$170,000	24.82
\$180,000	26.28
\$190,000	27.74
\$200,000	29.20
\$210,000	30.66
\$220,000	32.12
\$230,000	33.58
\$240,000	35.04
\$250,000	36.50
\$260,000	37.96
\$270,000	39.42
\$280,000	40.88
\$290,000	42.34
\$300,000	43.80
\$310,000	45.26
\$320,000	46.72
\$330,000	48.18
\$340,000	49.64
\$350,000	51.10
\$360,000	52.56
\$370,000	54.02
\$380,000	55.48
\$390,000	56.94
\$400,000	58.40
\$410,000	59.86
\$420,000	61.32
\$430,000	62.78
\$440,000	64.24
\$450,000	65.70
\$460,000	67.16
\$470,000	68.62
\$480,000	70.08
\$490,000	71.54
\$500,000	73.00

Spouse/DP term life and AD&D

Coverage amount	Deduction
\$5,000	\$0.73
\$10,000	1.46
\$15,000	2.19
\$20,000	2.92
\$25,000	3.65
\$30,000	4.38
\$35,000	5.11
\$40,000	5.84
\$45,000	6.57
\$50,000	7.30
\$55,000	8.03
\$60,000	8.76
\$65,000	9.49
\$70,000	10.22
\$75,000	10.95
\$80,000	11.68
\$85,000	12.41
\$90,000	13.14
\$95,000	13.87
\$100,000	14.60

Child term life

One premium provides coverage for all eligible children

\$5,000	\$0.15 bi-weekly
\$10,000	\$0.29 bi-weekly

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

In certain circumstances the coverage you elect may require us to approve Evidence of Insurability (EOI) before coverage takes effect. If EOI is required, you should receive correspondence from us indicating we have approved your EOI before your employer deducts or submits premiums for the portion of coverage requiring EOI. If you have questions about whether EOI is required for coverage or has been approved, contact us at 866-889-6221.

Insurance products are issued by Minnesota Life Insurance Company. Minnesota Life Insurance Company is not an authorized New York insurer and does not do insurance business in New York. The company is headquartered in St. Paul, MN. Minnesota Life Insurance Company is solely responsible for the financial obligations under the policies or contracts it issues.

Products are offered under policy form series 14-31700.9.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its subsidiaries. Minnesota Life Insurance Company is a subsidiary of Securian Financial Group, Inc.



securian.com

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Have you elected a beneficiary?

Do I need to designate a beneficiary annually?

No. However, important events such as marriage, birth/adoption of children, divorce or death may change how you want your life insurance benefit paid.

Choosing a beneficiary

Your beneficiary can be a person, a charity, a trust or your estate. You can split the benefit among multiple beneficiaries as long as the total percentage of the proceeds equals 100 percent.



Primary beneficiary The person(s) named will receive the benefit. If a primary beneficiary is not alive at the time of a claim, the benefit will be split among any remaining primary beneficiaries before it is paid to a contingent beneficiary.



Contingent beneficiary If the primary beneficiaries are no longer living, the benefit is paid to this person or persons.



Default beneficiary If you do not name a beneficiary, policy benefits will be paid to the default beneficiary listed in the certificate of insurance.

Can I name someone living in another country?

Yes. If your beneficiary lives outside of the U.S., please be sure your designation information is complete, with full name and address.

Can I designate a minor?

Minors cannot directly receive life insurance proceeds. There are, however, a number of ways the proceeds can be used and managed for minor children. To determine the best approach for your life insurance benefits, you should consult an estate planning attorney.

Questions?

For more information on this topic, visit securian.com/beneficiary-info.

Insurance products are issued by Minnesota Life Insurance Company or Securian Life Insurance Company, a New York authorized insurer. Minnesota Life is not an authorized New York insurer and does not do insurance business in New York. Both companies are headquartered in St. Paul, MN. Product availability and features may vary by state.

Each insurer is solely responsible for the financial obligations under the policies or contracts it issues.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its subsidiaries. Minnesota Life Insurance Company and Securian Life Insurance Company are subsidiaries of Securian Financial Group, Inc.

Securian Financial Group, Inc.
lifebenefits.com

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Manage your group term life insurance beneficiary online

1

To designate, view or change your group term life insurance beneficiary, visit LifeBenefits.com and log in with the user ID and password below.

User ID: PBC followed by a number assigned by Securian. If you do not know your user ID, use the forgot user ID function on LifeBenefits.

Initial password: Your eight-digit date of birth (MMDDYYYY) followed by the last four digits of your Social Security number

If you have previously accessed LifeBenefits.com, use the password you set up during your previous visit.

If you have questions or are not able to log in, please contact group customer service directly at **1-866-293-6047**.

The image shows the 'Account login' page for Securian Financial. It features the Securian Financial logo at the top. Below the logo, the text 'Account login' is prominently displayed. There are two input fields: 'User ID' and 'Password'. To the right of the 'User ID' field is a link that says 'Forgot your ID?'. To the right of the 'Password' field is a link that says 'Forgot your password?'. At the bottom of the login section is a blue 'Log in' button.

2

To designate your beneficiary for the first time, click "Begin" in your tasks.

The image shows the 'Welcome, JOHN' page on the Securian Financial website. At the top, it says 'Welcome, JOHN'. Below this, there is a 'Task' section with a sub-header 'Name the beneficiaries for your Term Life coverage.' and a green 'Begin' button with a red arrow pointing to it. To the right of the 'Task' section is a 'My coverage summary' section with a sub-header 'Beneficiary details' and a link 'Manage your beneficiary designation online'. Below this is a 'Term Life' section with a warning icon and the text 'Beneficiary needed'. On the far right, there is a green box titled 'How much life insurance is enough?' with a link 'Go to calculator'.

3

To update an existing designation, click "View details" under your enrolled coverages, then select "Edit beneficiaries."

The image shows the 'Enrolled Coverages' page on the Securian Financial website. At the top, it says 'Welcome!' and 'Need help? Get it right! Review your coverage options, verify or modify beneficiary.' Below this is a 'Get started' button. The main section is titled 'Enrolled Coverages' and contains a table with the following data:

Status	Effective Date	Beneficiary Status	Action
Active	01/01/2020	Designation on file	View details

Below the table, there is a section for 'Term Life' with a red arrow pointing to the 'View details' link. The table also includes columns for 'Coverage type', 'Amount', and 'Monthly premium'.



4

You can select one beneficiary, or split the benefit among multiple beneficiaries, as long as the total shares equal 100 percent. If you have any questions about beneficiaries or how to designate, click on the Beneficiaries 101 link located at the top of the web page in the blue box.

Help & FAQs

Beneficiary designation

Choose beneficiaries
Beneficiary detail
Verify designation
Sign and submit

Choose beneficiaries

New to beneficiary designations? Learn more with Beneficiaries 101.

Enter the names of your beneficiary(ies).

Coverage

Term Life

Primary beneficiary(ies)

Beneficiary's full name	Relationship	Share %	
Jane Wilson	Spouse	100	Remove

[Add primary beneficiary](#)

Total share %: 100

Share percentages must total 100%.

Contingent beneficiary(ies)

Beneficiary's full name	Relationship	Share %	
Sam Wilson	Son	50	Remove
Sally Wilson	Daughter	50	Remove

[Add contingent beneficiary](#)

Total share %: 100

Share percentages must total 100%.

[Cancel](#) [Complete later](#) [Next](#)

5

You will need to know the first and last names of your beneficiary. If you also have their address, phone number, date of birth and/or Social Security number, this can be helpful at the time of claim to expedite payment.

Additional information

These details can be invaluable in the event of a claim. If you don't have this information available right now, you may return in the future to add it.

This beneficiary has the same address as:

Street address 1

Street address 2

Street address 3

City State/province Postal code

Country

USA

Date of birth Social Security number

mm/dd/yyyy

Phone

☐ This is a number outside the U.S.

What if I don't know their information?

If you don't have the additional information for a beneficiary available, you can still complete your designation.

☐ I don't have the additional information for Jane Wilson available.

☐ I don't have additional information for Jane Wilson or any of my remaining beneficiaries and would like to skip this step.

6

Verify that all information is correct.

HOME Help & FAQs

Beneficiary designation

Choose beneficiaries
Beneficiary detail
Verify designation
Sign and submit

Verify designation

Please review this information and verify it is correct.

Coverage

Term Life

Primary beneficiary [Edit beneficiary](#)

Beneficiary detail	Relationship	Share %
Name: Jane Wilson Address: 1234 N Main St. St. Paul, MN 55101 USA Date of birth: 12/16/1954 Social Security number: ***-**-5555 Phone: 651-665-5200 Edit detail	Spouse	100.00

Contingent beneficiaries [Edit beneficiaries](#)

Beneficiary detail	Relationship	Share %
Name: Sam Wilson Address: 1234 N Main St. St. Paul, MN 55101 USA Date of birth: 12/01/1990 Social Security number: ***-**-3333 Phone: 651-665-5200 Edit detail	Son	50.00
Name: Sally Wilson Address: 1234 N Main St. St. Paul, MN 55101 USA Date of birth: 01/01/1992 Social Security number: ***-**-1111 Phone: 651-665-5200 Edit detail	Daughter	50.00

[Back](#) [Cancel](#) [Complete later](#) [Next](#)

7

Sign and submit via electronic signature.

Help & FAQs

Beneficiary designation

Choose beneficiaries

Beneficiary detail

Verify designation

Sign and submit

Sign and submit

This designation will replace any previous designations, immediately or on the effective date of your policy, whichever is later. You can return to this website to review or change your designation at any time.

Email notification

You will automatically receive notification of your beneficiary designation by postal mail. If you would like, we will also send you an email confirmation.

☐ I would like to receive an email confirmation at the following address:

Email address

Electronic signature

Please select your response to the following statement: By selecting "I agree" I hereby affix my electronic signature, I agree to be bound, in all respects, as if I were affixing my handwritten signature to the document. I have read and understand the terms of use and the electronic signature requirements. The information submitted is true and complete to the best of my knowledge and belief.

☐ I agree

☐ I do not agree

Back

Cancel

Complete later

Submit

8

Once your designation is made, you will receive a beneficiary confirmation statement in the mail. If you need to change or update your beneficiary, changes can be made online at any time.

Help & FAQs

Beneficiary designation

Make a new beneficiary designation

Begin

Below are the details of your current beneficiary designation.

Term Life

as of 04/01/20XX

Edit beneficiaries

Primary beneficiary

Name	Relationship	Share %
Wilson, Jane	Spouse	100.00

Contingent beneficiaries

Name	Relationship	Share %
Wilson, Sam	Son	50.00
Wilson, Sally	Daughter	50.00



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If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.



Employee Benefits Solutions

Products issued by: Minnesota Life Insurance Company or
Securian Life Insurance Company

Built-in benefits for life's unexpected moments

Real support for everyday life at no additional cost

When life takes an unexpected turn, such as a medical emergency abroad or the loss of a loved one, having the right support makes all the difference. Your group insurance includes a network of professionals ready to help in moments like these, at no additional cost and with no sign-up required. You, your spouse/domestic partner and your children can access these resources anytime.



Learn more

Take a few minutes to explore what's available so you know where to turn when life calls for backup.

For more information, visit:

securian.com/pbc-insurance



Legal, Financial and Grief resources - TELUS® Health

Talk to attorneys, financial professionals and grief counselors when life gets complicated – whether you're drafting a will, working through a budget or navigating a loss.

Explore resources on LifeBenefits.com/LFG (username: lfg, password: resources) or connect with a professional at **1-877-849-6034**.



Travel assistance - RedpointWTP LLC

Once you're 50+ miles from home, help is a phone call away – day or night. Replace a lost passport, locate a doctor, arrange emergency evacuation or track down luggage. Save the number before you go; services must be coordinated through Redpoint to be covered.

Learn more at LifeBenefits.com/travel or call **1-855-516-5433** in the U.S. and Canada, or **+1-415-484-4677** if you're traveling abroad.

**Legacy Planning Resources** - Securian Financial

Online tools guide you through end-of-life wishes, directives and survivor support – and concierge services help your beneficiaries when the time comes.

Visit securian.com/legacy to access tools and resources.

**Empathy** - by The Empathy Project Inc.

Empathy pairs your family with a dedicated Care Manager to help you handle the practical to-dos, from closing accounts to navigating probate, while also offering tools to support emotional well-being.

Beneficiaries will be invited to engage Empathy when the life insurance claim is paid.

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

Value-added services availability and features may vary by state. The relationship between The Empathy Project Inc. and Securian Financial Group, Inc., is that of independent contractor. These services are not affiliated with Securian Financial Group, Inc., or its group contracts and may be discontinued at any time. Certain terms, conditions, and restrictions may apply when utilizing the services. The Empathy Project Inc. is responsible for the services it provides and does not have the power or authority to obligate or bind Securian Financial Group, Inc., in any manner beyond that which is contractually agreed to by the parties.

Services provided by TELUS Health and RedpointWTP LLC are their sole responsibility. The services are not affiliated with Securian Financial or its group contracts and may be discontinued at any time. Certain terms, conditions and restrictions may apply when utilizing the services. To learn more, visit the appropriate website.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its subsidiaries. Minnesota Life Insurance Company and Securian Life Insurance Company are subsidiaries of Securian Financial Group, Inc.



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DISABILITY INSURANCE

UNITEDHEALTHCARE



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

LATE ENROLLMENT - Approval may be contingent on medical underwriting

UnitedHealthcare is providing an annual enrollment period for employees not currently enrolled in short-term disability or upgraded or voluntary long-term disability without requiring Evidence of Insurability (without answering health questions). During your Employer's Annual Enrollment Period, certain Evidence Of Insurability requirements will be waived with respect to STD and LTD Insurance. Annual Enrollment Period means the period designated each year by your Employer when you may change insurance elections.

Pre-existing condition limitation in accordance with the long-term disability policy apply. Outside of your new hire window (or when you first become eligible for the disability coverage) and outside of the annual enrollment period, you will be required to successfully complete Evidence of Insurability (EOI) and must be approved by the carrier for coverage to become effective if you:

- Did not enrolled in the STD coverage when you initially became eligible for the coverage and wish to elect STD coverage thereafter
- Are currently enrolled in the Core LTD coverage and wish to upgrade to the Buy-Up/Voluntary coverage
- Are not currently enrolled in the Core LTD coverage and wish to elect the Buy-Up/Voluntary coverage

SHORT-TERM DISABILITY

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

Short-Term Disability Insurance

EE Only - Annual earnings / 52 weeks x 67% x \$.26 / 10 = monthly premium ÷ 2 = bi-weekly premium

Eligibility: Must be an active employee working 30 hours or more per week

- Employees who did not enroll in this benefit when first eligible for the coverage or apply for coverage outside of the annual enrollment period, will be required to successfully complete Evidence of Insurability (EOI) and must be approved by the carrier for coverage to become effective
- Benefit amount – 67% of your earnings reduced by deductible income
 - Maximum weekly benefit: \$1,200
 - Minimum weekly benefit: \$100
- The maximum benefit period = 90 days per the policy or until you no longer qualify whichever occurs first, following the initial 14 days of continuous disability
- Please note a typical maternity leave benefit is payable for six (6) to eight (8) weeks - depending on the type of delivery - and is reduced by the 14 day waiting period
- Sick leave and Work related disabilities are not covered under the STD plan offset the benefit – vacation pay does not
- If chosen, benefit is paid entirely by the employee on a post-tax payroll deduction basis
- Active Work Requirement: If you are incapable of Active Work because of Physical Disease, Injury, Pregnancy or Mental Disorder on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible member

Note: If you are a worker of the CWA bargaining unit, please review your contract. The CWA offers its own short term disability benefit program separate and apart from this plan, which is considered deductible income under this plan. Please contact your union representative with questions regarding short term disability benefits available to you under the CWA contract

LONG-TERM DISABILITY (LTD)

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

Long Term Disability Insurance

- Employer Paid Core LTD – EE Only – must have HMO or CHOICE medical plan. Monthly benefit is 50% of monthly gross/max \$1000/month. *100% Employer paid.
- Voluntary /Buy-Up LTD – EE Only - Monthly benefit is 60% of monthly gross / max \$5000/month. 100% employee paid.
- To calculate the cost of coverage, use the following formula:
- Annual earnings / 12 = monthly earnings
(note the maximum coverage monthly earnings is \$5,000)
- covered monthly earnings * rate = subtotal / 100 = monthly cost

Key Features:

- Duration of Benefit: To age 65, if age 59 or under at commencement of disability; a different schedule applies to disabilities commencing at or after age 60
- Elimination Period: 90 days from date of total disability Conditions Insured: Accident and Sickness
- Benefit Reductions - Benefits are reduced with Social Security, Workers’ Compensation, any disability or retirement benefit you receive or are eligible to receive under your employer’s retirement plan, or other group disability benefits you may have (review Certificate for complete list)
- Disabled or Disability means You are not Actively at Work and:
 1. You are unable to perform some or all of the Essential Duties of Your Occupation due to Sickness or Injury, or
 2. Your Disability Earnings are 80% or less than Your Indexed Long Term Disability Pre-Disability Monthly Earnings solely due to the same Sickness or Injury; and
 3. You are under the Regular Care of a Physician
- Pre-existing Exclusions - If disability occurs within the first 12 months of your coverage and is related to a condition that you received treatment for or took prescribed medication in the 3 months prior to your effective date, the disability is not covered
- Definition of Disability: Two years in your “own occupation”, then any occupation thereafter which you are reasonably suited for by training, education or experience
- Evidence of Insurability (EOI) may be required to upgrade from the Core plan. Employees who did not enroll in this benefit when first eligible for the coverage or apply for coverage outside of the annual enrollment period, will be required to successfully complete Evidence of Insurability (EOI) and must be approved by the carrier for coverage to become effective
- Visit myuhcfp.com

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

- This benefit is intended to protect employees who are disabled for over 90 days and unable to return to work because of a covered disability
- The benefit offers HMO and CHOICE health plan participants a maximum monthly benefit of up to \$1,000 (\$100 minimum monthly benefit)

This benefit is offered at no cost to the employee and is available only to employees who participate in the UNITED HEALTHCARE **HMO health plan or CHOICE health plan** through BCC

- Benefits Payable: 50% of your monthly gross salary to a maximum \$1,000 monthly benefit
- You can increase the percentage of your monthly benefit amount to 60% of your monthly covered earnings and your maximum monthly benefit to \$5,000 by purchasing additional protection with the voluntary or Buy-up LTD plan

Voluntary/Buy-up LTD Plan

- This optional level allows you to **increase** the percentage of your monthly benefit amount to 60% of your monthly covered earnings and your maximum monthly benefit to \$5,000
- Participants who are participating in either the UNITED HEALTHCARE HMO or CHOICE health plan will receive credit for the value of the Core plan when electing the Buy-Up LTD plan
- Benefits Payable: 60% of your monthly gross salary to a maximum \$5,000 monthly benefit 5,000 (\$100 minimum monthly benefit)



How your plan works

If you have an eligible short-term or long-term disability claim, your plan will pay a portion of your paycheck each week/month. This provides you income replacement to help you and your family pay for expenses like rent, medical bills, food and more. With your disability plan, you can rely on:

- ✓ **Claims support to help you focus on getting well without added stress**
- ✓ **Personal support to help you get back to your job more quickly and safely**
- ✓ **A Member Assistance Program (MAP) to help you and your family with personal and confidential support***



How to file a claim

If you have any questions about this process, please call our claim service team at **1-866-556-8298** between 8 a.m. and 8 p.m. ET.

Member claims portal – Log in to myuhcfp.com and click the “Start a Claim” icon to complete and submit a claim online



When payments begin

If you are enrolled in both short-term and long-term disability and your disability claims have been approved, you’ll start to receive your long-term disability monthly benefit payments after your short-term disability weekly benefits end. You do not need to satisfy another elimination period. You can use your payments for anything, including:

- Health plan deductible
- Mortgage/rent
- Groceries
- Other medical bills
- Utilities
- Child care

If you only have long-term disability, you will have to wait for a short period of time after you submit your claim (known as the elimination period) before you’re eligible to receive monthly payments.

Understanding the elimination period

- The elimination period begins the day you become disabled
- To find out the length of your plan’s elimination period, please see your Certificate of Coverage

* The Member Assistance Program (MAP) may not be available with some group disability plans. Please see your certificate of coverage or contact your employer for benefit details.

FLEXIBLE BENEFITS PLAN

P&A GROUP



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

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

- **Healthcare FSA contributions:**
\$260 min - \$3,400* max annually or \$10.00 - \$130.77 bi-weekly
- **Dependent Care FSA contributions:**
\$260 min - \$7,500 max annually or \$10.00 min – \$288.46 biweekly

*Annual limit will be increased to inflation adjusted amount, once announced by IRS.

FLEXIBLE SPENDING ACCOUNT



County of Palm Beach

FSA Rules to Remember

PLAN YEAR

January 1, 2027- December 31, 2027

GRACE PERIOD

This provision gives you two and a half months after the end of the plan year to incur eligible expenses, as long as you are actively enrolled as of the last day of the plan year. Participants have until March 15, 2028 to incur expenses during the plan year.

RUN-OUT PERIOD

You have until April 30, 2028 to submit for expenses incurred during the plan year.

USE OR LOSE RULE

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

Reminder

Over-the-counter (OTC) medications are now reimbursable under Flexible Spending Accounts without requiring a prescription or completing a Letter of Medical Necessity Form. Menstrual care products are also now reimbursable as eligible expenses, including tampons and pads.

FSA CALCULATOR

Estimate your calculated savings when you enroll in an FSA. Click [here](#) to access the calculator!

Your Guide to Pre-Tax Savings



WHAT IS A FLEXIBLE SPENDING ACCOUNT?

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

ACCOUNTS AVAILABLE

Health Flexible Spending Account

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

Minimum annual election amount: \$260

Maximum annual election amount: \$3,400

Dependent Care Assistance Account

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

Maximum annual election amount: \$7,500

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

www.padmin.com | (716) 852-2611

FLEXIBLE SPENDING ACCOUNT



P&A BENEFITS CARD

Your employer offers a Benefits MasterCard for employees who participate in the plan. The Benefits MasterCard works like a debit card. When you incur an eligible expense, swipe your card at the point-of-service and the expense will automatically be deducted from your FSA balance. If you are unable to use your Benefits Card, you can still be reimbursed for all eligible expenses. Save your receipt and submit a claim to P&A Group using one of the methods below. For all purchases, we encourage you to save your receipts in case documentation is requested. A new card will be mailed to your home mailing address prior to the card expiring.

NOTE: This card cannot be used at an ATM machine to withdraw cash.



MOBILE APP

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



- ✓ Register for account alerts
- ✓ Submit claims
- ✓ Order a Benefits Card
- ✓ Check your account balance & more!

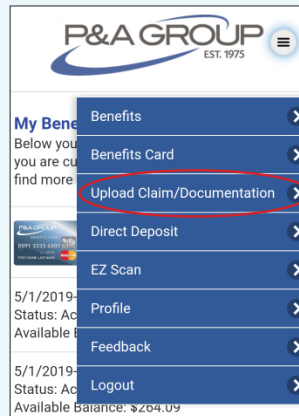
4 WAYS TO SUBMIT YOUR CLAIMS

P&A Group Mobile App

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

QuikClaim from Your Smartphone

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



Electronic Claim Upload from Your Computer

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

Fax or Mail a Paper Claim

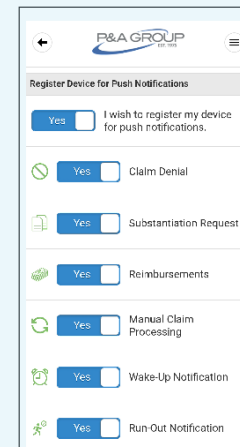
Complete a claim form and fax or mail it to P&A Group. Claim forms are available when you log into your account at www.padmin.com.

FAX: (877) 855-7105

MAIL: P&A Group 6400 Main Street, Suite 210 Williamsville, NY 14221

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

Opt-in to get account alerts



QUESTIONS?

HRS: Monday - Friday, 8:30 a.m. - 10:00 p.m. EST.

PH: (716) 852-2611

WEB: www.padmin.com

MAIL: 6400 Main Street,
Suite 210
Williamsville, NY 14221

SUPPLEMENTAL INSURANCE WASHINGTON NATIONAL

Safeguard your physical & financial health with
supplemental insurance

Review your supplemental benefit options and protect yourself and your family from unforeseen medical cost, diagnosis, and emergencies.

Medical emergencies are unpredictable and expensive, and your employer health plan, or private health insurance may only cover a portion of the costs. Our supplemental health policies offer benefits to help protect your family financially from the high cost of hospital stays, critical illnesses, injuries, & more.

How would a hospital stay, or illness affect you financially?

Beware of these common out-of-pocket expenses:

Deductible. Before your major medical insurance starts paying benefits, you must meet your deductible.	Copays. These are fixed amounts you pay for covered services after you meet your deductible.
Travel to and from where you receive care: Receiving care for serious illnesses, such as cancer, may require you to seek treatment at facilities not in your local area.	Everyday expenses. Bills and expenses don't stop when you're unable to work due to an injury.

We offer many coverage options to fit your needs, including ones that cover:

- Hospital stays
- Doctor Appointments,
- Surgeries, Lab Tests & more
- Emergency Room
- Urgent Care Visits
- Cancer & Accidental Injuries

Be assured...we've got you covered.

Representatives will be at each work location in November.

« Scan this QR code or visit the link below to review the available plan options. <https://www.mybensite.com/pbcgov/>

WHY WASHINGTON NATIONAL?

Our policies offer these assurances:

Flexibility.

Because cash benefits are paid directly to you, not a doctor or hospital, you have no restrictions on how you use your benefits.

Portability.

This allows you to keep your policy, even if you change jobs, move to a different state, retire or go on Medicare.

Premiums stay the same.

Your rates cannot be increased unless all rates of that kind are raised in your state.

Guaranteed renewability for life.

Your policy is guaranteed renewable as long as you pay the required premiums on time.

And the best part is, if you don't use the coverage, our Return of Premium benefit returns your premiums— minus claims—after 20 years*

(or at age 75, whichever is first on the Hospital Plan)



*The return of premium (ROP) or cash value (CV) (in MO, "cash return") benefit is subject to state and product availability. The benefit has an additional charge and may pay minus claims or regardless of claims based on the policy selected. The policy must remain in force until the end of the ROP/CV period for the benefit to be paid.

LIMITED-BENEFIT POLICIES. These policies have limitations and exclusions. For costs and complete details of coverage, contact your agent. Policies underwritten by Washington National Insurance Company, home office Carmel, IN. Policies, benefits and riders subject to state availability. Premiums are based on the level of coverage selected.

Washington National Insurance Company

Home Office: Carmel, IN

WashingtonNational.com

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Fact Sheet

The Program:	The Employee Assistance Program (EAP) is a service offering CONFIDENTIAL professional assistance to all employees of the Palm Beach County Board of County Commissioners and the employee's immediate family members for issues such as emotional, stress, alcohol or drugs, financial, family, marital, legal, health and job-related. "Lunch & Learn" programs on these issues are also offered.
The Appointment:	Self-referrals - an employee or family member may call the EAP office at (561) 233-5460 for information or to make an appointment to discuss personal problems. Management Referrals - an employee's supervisor/manager may suggest to an employee that he/she seek help when there is a work performance problem or when specific on-the-job incidents indicate that an employee's performance is being affected by personal problems
Confidentiality:	Every effort is made to ensure privacy. No one will know of your participation in the EAP without your permission, except as required by law or in a situation deemed potentially life-threatening by the EAP counselor.
The Hours:	Flexible hours are maintained to accommodate employees and family members.
The Cost:	There is no charge for any in-house EAP service. Outside referral services may be covered by medical insurance plans or community resources who operate on a sliding scale basis.

For additional information or to schedule a **CONFIDENTIAL** appointment, please call us at: **(561) 233-5460**. You can visit our **Intranet** website at:
<http://pbc/riskmanagement/employeeassistance/>

END OF COVERAGE

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

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

Continuation Group Health Coverage

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

Retiree Insurance – Continuation of Coverage for Retirees

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

Life Insurance portability/conversion

Employees who were previously insured for Basic and Additional Term Life Insurance coverage may elect to continue their in-force insurance, as well as any in-force insurance on their dependents. Employee must apply for portability from the carrier within 60 days from the date coverage would otherwise terminate.

NOTICES

TO: ALL COUNTY PERSONNEL

FROM: VERDENIA C. BAKER
COUNTY ADMINISTRATOR

PREPARED BY: RISK MANAGEMENT DEPARTMENT

SUBJECT: GROUP HEALTH AND LIFE INSURANCE

PPM #: CW-P-023

ISSUE DATE
April 29, 2025

EFFECTIVE DATE
April 29, 2025

PURPOSE:

To provide a comprehensive selection of group health and life insurance plans to full time County employees and eligible dependents of the Board of County Commissioners (the Board).

UPDATES:

Future updates to this PPM are the responsibility of the Director of Risk Management.

AUTHORITY:

- Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as may be amended
- F.S. 112.0801, as may be amended
- Palm Beach County Code, Chapter 2, Article I, Section 2-6, as may be amended
- Health Insurance Portability & Accountability Act of 1996 (HIPAA), as may be amended
- Affordable Care Act (ACA), as may be amended
- Internal Revenue Code, as may be amended
- Section 125 Cafeteria Plan document, as may be amended
- Group Insurance plan documents (located on Risk Management/Group Insurance website under "Publications"), as may be amended
- Palm Beach County Merit Rules, as may be amended

DEFINITIONS:

Refer to **Attachment A** for a listing of definitions related to this PPM.

POLICY:

Group Health Insurance. A selection of group health insurance plans is provided by the County to eligible employees and their eligible dependents at varying levels of employee premium contribution as approved by the Board. Employee contribution levels are evaluated annually. Variable hour employees, including employees in intern, on-call, seasonal, temporary, substitute, or overlap status are eligible for **group health** coverage **only**, if they meet the definition of full-time employee in accordance with the Affordable Care Act and relevant Internal Revenue Code

definition of full-time employees. Variable hour employees who are deemed eligible following an initial measurement period are subsequently included in annual evaluations. Variable hour employees may drop in and out of eligibility for health coverage based on the annual evaluation results.

Group Life Insurance: Basic group life and accidental death and dismemberment insurance are provided by the County at no cost to eligible employees. Supplemental group life, accidental death and dismemberment insurance, spouse/domestic partner term life and dependent life insurance are available to employees through payroll deductions. The amounts of basic, supplemental, spouse/domestic partner and child life insurance available are computed in accordance with the flat rate offered by the contracted carrier, regardless of the employee's age or rate of pay.

Enrollment in supplemental life may be contingent on medical underwriting as determined by the contracted carrier.

At the time of hire and within the allowable time period prior to the effective date of coverage, permanent employees who work 30 hours or more a week may enroll in the group life insurance plan, choosing basic group life only, or additional and/or dependent group life coverage. The option of enrolling in additional group life may not be exercised at a later date than above described unless there is an official Open Enrollment period. A permanent employee is defined as an employee hired into a permanent full-time position and the employee is not employed in a part-time position (less than 30 hours per week).

Other Group Insurance: The Board also offers voluntary (employee pay-all) insurance plans, such as dental, short term, and long term disability policies. Employees who purchase these policies are subject to the same eligibility rules as in place for group health and life insurance.

Enrollment in long term and short term disability coverage may be contingent on medical underwriting as determined by the contracted carrier.

Group Insurance Coverage Effective Date: Coverage becomes effective on the first day of the month coinciding with or next following 60 consecutive days of employment. (Example: Hire date May 15, effective date of coverage August 1.)

A permanent Board employee who transfers from other than a full time employment category to full time permanent will be given the option to have coverage effective on the first day of the month immediately following his/her hire date with the Board provided the employee has been continuously employed in that permanent other than full-time position for at least 60 consecutive calendar days. An employee transferring from employment with a Palm Beach County Constitutional Officer or Palm Tran, without any break of service, will be given the option to have coverage effective on the first day of the month immediately following his/her hire date with the Board. Employees must be full time, scheduled to work 30 hours or more per week, to be eligible for coverage.

Elected officials and their appointed staff are eligible for group insurance coverage to become effective the first of the month following their hire date.

Election Changes: Election changes can only be exercised during the official annual Open

Enrollment period or within the allowable time period following a qualified family status change.

Proof of Eligibility: Employees may include their spouse, children (including step children, adopted children, foster children and/or children for which the employee is the legal guardian), domestic partner, domestic partner's children (including, adopted children, foster children and/or children for which the domestic partner is the legal guardian), under the County's health plans. Proof of eligibility is required for all dependents added to the employee's coverage. Required documentation, referenced in Table 1 below, shall be submitted to Risk Management/Group Insurance upon hire, or when dependents are added during the plan year. Staff, at its discretion, may also require the documents referenced above during the Open Enrollment period or any time during the plan year during random or formal file audits, or when circumstances arise that lead to a single file audit of an employee. It is hereby noted that when a third party is hired to conduct a dependent verification review, it may require additional information from what is noted herein.

If proof of eligibility is not provided with the plan enrollment, Risk Management/Group Insurance will request it. Documentation must be received within 60 days of the request by Risk Management/Group Insurance or the dependent may not be enrolled in, or remain in the plan(s). Such dependents would not be eligible for coverage until the next Open Enrollment period except in the case of a qualifying family status change. Qualified family status changes are defined in the applicable group insurance plan document and are also governed by Section 125 Cafeteria Plan document and includes events such as change in legal marital status, change in number of dependents, change in employment status, change in residence to outside the employer's network service area and changes to a dependent's eligibility status as well as HIPAA special enrollment rights. Employees are required to notify Risk Management within 30 days in the event of a qualified family status change and provide appropriate documentation. Refer to the following chart for required documentation.

Eligibility Categories	Required Documents
Spouse or Domestic Partner - Legal spouse - Domestic partner of the same or opposite sex	- Copy of page 1 of federal tax return of most current tax year as filed (personal and income information redacted) listing spouse OR: Copy of marriage license - Certificate or copy of executed, notarized and recorded Declaration of Domestic Partnership form (Palm Beach County Code, Chapter 2, Article I, Section 2-6) PLUS (Spouse OR Domestic Partner) - Proof marriage/partnership is still current (recurring monthly or quarterly household bill or statement of account listing spouse's/partner's name at employee's address within the past 60 days)
Child up to end of the month the child turns age 26	
Biological child	Official birth certificate (hospital birth record not acceptable)
Adopted child	Official adoption documents
Foster child	Official documents, placing the child in employee's care
Child placed into custody by a court order	Court documented guardianship papers (Power of Attorney is not acceptable)
Step child	Marriage license of marriage to biological parent of child and birth certificate for child that names the employee's spouse as a parent

Child of Domestic Partner	- Birth verification as indicated above, depending on type of child (biological, adopted, foster child, or child placed into custody of Domestic Partner by a court order) plus executed, notarized and recorded Declaration of Domestic Partnership form (Palm Beach County Code, Chapter 2, Article I, Section 2-6) PLUS - Proof partnership is still current (recurring monthly or quarterly household bill or statement of account listing partner's name at employee's address within the past 60 days)
Child born to an insured dependent of the employee	Official birth certificate of child born to the employee's insured dependent
Child age 26 to 30	
Unmarried child age 26 up to until the end of the calendar year in which the child reaches the age of 30, provided child does not have a dependent of his/her own, is a Florida resident or a full-time or part-time student, and is not covered under a plan of his/her own or entitled to benefits under Title XVIII of the Social Security Act.	- Official birth certificate (hospital birth record not acceptable) - Copy of driver's license OR - State-issued ID showing s/he is a Florida resident OR - Copy of current school registration, confirming full-time or part-time student status
Disabled Child	
Qualified child who is 26 or more years old and primarily supported by the employee and incapable of self-sustaining employment by reason of mental or physical handicap	- Official birth certificate (hospital birth record not acceptable) - Official adoption documents - Official documents, placing the child in employee's care - Court documented guardianship papers (Power of Attorney is not acceptable)
Documentation required for other qualified events	
Qualified family status change	Documentation
Dissolution of Domestic Partnership	Executed, notarized and recorded Declaration of Termination of Domestic Partnership form (Palm Beach County Code, Chapter 2, Article I, Section 2-6)
Divorce (divorced spouses are not eligible for dependent coverage regardless of the court decree)	Final Divorce Decree
Death	Death certificate

If it is determined that employees have covered dependents under these plans that are not eligible for coverage, the County reserves the right to require the return of all County-paid premiums, any associated claims costs paid on behalf of the ineligible dependent, and will pursue any and all other remedies available under law. The employee may also be subject to disciplinary action, up to and including termination.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison. Coverage may be retroactively terminated (rescinded) if it is determined that a covered individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the applicable group insurance plan or benefit. Prior notice to the enrollee will be issued should coverage be rescinded.

As indicated by the applicable group insurance plan documents anyone who is eligible as an Employee will not be considered as a Dependent.

Opt-Out Benefit: The Board may offer an opt-out program to employees who have waived the County's health coverage, are covered by a health plan elsewhere, and have verified the other coverage. The Opt-Out benefit does not affect an employee's eligibility for group insurance benefits other than health coverage.

A pre-determined amount is paid to eligible employees per pay period through an employer payroll contribution.

The Opt-Out benefit is not provided to any employee who is enrolled in a plan (as an employee or a dependent) to which the Board contributes – including the health plan of the Board, Palm Tran and Supervisor of Elections as well as any other entities that may join the Board health plan in the future. Employees who are enrolled in the health plan of Palm Beach County Fire Rescue are also excluded from the Opt-Out benefit as long as Board contributes towards the funding of the Fire Rescue health plan in accordance with the provisions of the Collective Bargaining Agreement.

Employees and their dependents who opted out of the Board's health plan cannot enroll or re-enroll in the health plan of Palm Beach County until the next annual Open Enrollment period, unless coverage ceases in the other group plan; acceptable documentation must be received by Risk Management/Group Insurance within 30 days from the date the other coverage ceased, or, unless the employee experiences another qualified family status change during the year and notifies Risk Management of the same within 30 days of the event.

All Opt-Out participants (including new and current) must actively enroll or re-enroll in the Opt-Out program each Plan Year and must annually show their proof of other coverage. Proof of other coverage must state employee's name.

Continuation of Coverage under COBRA: In compliance with COBRA, employees who terminate employment for other than gross misconduct or who reduce their work hours to less than 30 hours per week will have the option to continue their benefits for up to 18 months.

Employees or qualified beneficiaries of the employee who are eligible for 18 months of continuation coverage may qualify for an additional eleven months of COBRA continuation for a total maximum of 29 months, if the individual meets the qualification of a disability extension as outlined under COBRA.

Qualified beneficiaries of employees have an option to continue insurance for up to 36 months if coverage is lost due to divorce, death of the employee or ineligibility of a dependent child.

Qualified individuals may be requested to pay the full premium cost for COBRA coverage up to 102 percent of cost of the plan; individuals eligible for an eleven month disability extension, may be charged up to 150 percent of the cost of the plan.

Retiree Continuation Benefit: In accordance with F.S. 112.0801 employees who retire in accordance with the provisions of the Florida Retirement System (FRS) and who begin receiving FRS retirement benefits **immediately** after retirement from County employment are eligible to continue their health and dental insurance coverage for themselves and eligible dependents at the full premium cost. Retirees may also elect retiree life insurance.

Eligible employees must enroll in retiree benefits within 31 calendar days of retirement to participate in retiree benefits. Enrollments received outside of this deadline will not be accepted, nor will the annual Open Enrollment periods apply.

Retirees are required to pay by deduction from their FRS Pension Plan monthly payments, if possible. An initial self-payment may be required at the time of retirement. Any retiree not a part of the FRS, or whose monthly pension payment is not sufficient to cover the retiree insurance premium cost as well as FRS Investment Plan members, will be set up for premium collections through a billing service designated by Risk Management. Automatic payment is the standard payment method for retiree premium payments with the billing service.

Retirees must continuously remain in the plan, and cannot return to the plan if a break in coverage occurs.

RESPONSIBILITIES:

Employees are responsible for actively participating in the group insurance enrollment processes. This includes thoroughly reviewing available choices and contacting Risk Management with any group insurance questions, concerns, or for assistance with elections.

Employees are responsible for completing enrollments within the stated deadlines and via the benefits system that is made available to employees.

Employees must provide required documentation, including dependent verification documents and annual proof of other coverage by stated deadlines to Risk Management. Dependent Social Security numbers are required for medical plan enrollment due to federal requirements.

Certain programs, such as Flexible Spending Accounts (FSAs) and Opt-Out credit program must be actively re-elected every year and will not renew automatically. For the Opt-Out credit program,

proof of other coverage must be submitted by the employee to Risk Management and verified by Risk Management every year.

Employees are responsible for reviewing confirmation statements and group insurance deductions and credits on paychecks and notify Risk Management of any discrepancies immediately.

PROCEDURES:

Administration of enrollment procedures and establishment of correct dates of coverage for new employees as well as for changes desired by existing employees are administered by Risk Management.

Coverage termination dates are determined by the applicable Group Insurance benefit plan document. The Payroll section of the Finance Department issues any applicable refunds.

Premium deductions are automatically processed by the Payroll department by way of the applicable benefit administration system. The deduction method is established by Risk Management in accordance with available automated premium deduction methodology, which may result in premium deductions starting after a coverage effective date as well as premium deduction for terminated coverage being processed with a paycheck that falls into a month following coverage termination, based on the pay period dates, when the pay period for which the paycheck is processed, including any dates where group insurance coverage was in force.


VERDENIA C. BAKER
COUNTY ADMINISTRATOR

Supersession History:

1. A.O. 6-8 effective 09/13/1983
2. PPM# CW-P-023, effective 07/01/1988
3. PPM# CW-P-023, effective 08/15/2007
4. PPM# CW-P-023, effective 06/01/2009
5. PPM# CW-P-023, effective 02/22/2012
6. PPM# CW-P-023, effective 05/23/2017

ATTACHMENT A

DEFINITIONS

Accidental death and dismemberment insurance - Accidental death and dismemberment insurance is coverage that applies to accidental death or dismemberment by accidental injury.

Basic group life insurance - Basic life insurance is term life insurance that is paid for by the County and is provided at no cost to the employee.

COBRA - On April 6, 1986, Congress enacted the Consolidated Omnibus Budget Reconciliation Act of 1986. COBRA requires employers to offer employees and qualified beneficiaries the opportunity to temporarily continue their group health plan coverage under certain circumstances in which they otherwise would lose coverage.

Employee Contributions - Portion of group insurance premium amounts paid by the employee.

HIPAA - Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Long term disability - Provides income to an employee who is unable to work for an extended period of time, due to a disabling non-work related injury or sickness.

Open Enrollment period - The annual event when employees can make changes to their group insurance benefits.

Qualified family status change - Employees or eligible dependents may experience changes in status due to a life event such as marriage, divorce, birth, change in employment status that may allow the employee to change his or her coverage, within allowable timelines and consistent with the change that occurred.

Section 125 - An Internal Revenue Code section that governs pre-tax payment of insurance premiums.

Short term disability - A voluntary program designed to cover any gap in an employee's existing sick leave accumulation until the employee recovers or becomes eligible for long term disability (if enrolled).

Supplemental group life insurance - A voluntary, additional group term life coverage that employees may apply for to insure their own life.

Supplemental group accidental death and dismemberment insurance - A voluntary, additional life insurance that employees may apply for to insure against accidental death or dismemberment by accidental injury.

Variable hour employee - The ACA defines an employee as variable if, based on the facts and circumstances on the employee's start date, an employer cannot determine whether the employee

measurement period because the employee's hours are variable or uncertain. This may include employees in positions classified as student, on-call, seasonal, temporary; as well as part-time positions scheduled less than 30 hours per week.

Voluntary supplemental benefits – Policies that may cover out-of-pockets costs for deductibles, copays, and coinsurance and other related costs not paid by a medical plan arising out of an accident, cancer diagnosis or a hospitalization, in accordance with the terms of the policy.

Revised 03/2025

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

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

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

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

Section 1. Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

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

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

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

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

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

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

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

**NOTICE OF PRIVACY PRACTICES FOR PROTECTED
HEALTH INFORMATION**

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

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

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

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

SUD Treatment Information.

We may receive or maintain substance use disorder (“SUD”) treatment records that originate from certain programs or activities related to substance abuse education, prevention, training, treatment, rehabilitation, or research that are protected under 42 C.F.R. Part 2 (“Part 2 Program”). If we receive or maintain your records from a Part 2 Program pursuant to a general consent that you provided to the Part 2 Program authorizing use and disclosure of your Part 2 Program records for purposes of treatment, payment, or health care operations, we may use and disclose those records for treatment, payment, and health care operations as otherwise described in this Notice, subject to the same rights, restrictions, and protections. If, however, we receive or maintain your Part 2 Program records pursuant to a specific written consent that you provided to us or to another third party, we will use and disclose those

records only to the extent expressly permitted by that consent. Any SUD record protected health information that was disclosed may be subject to redisclosure. We will not use or disclose your Part 2 Program records, or testify or provide evidence describing the information contained in those records, in any civil, criminal, administrative, or legislative proceeding conducted by any federal, state, or local authority against you, unless such use or disclosure is expressly authorized by your written consent or by a court order issued after notice to you.

Uses and disclosures that require your consent

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

Uses and disclosures that require your written authorization

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

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

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

- the information is directly relevant to the family or friend's involvement with your care; and

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- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

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

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

1. When required by law.
2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. When required for law enforcement purposes (for example, to report certain types of wounds).
7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement

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official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
9. The Plan may use or disclose PHI for research, subject to conditions.
10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
12. We may use or disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ bank as necessary to facilitate organ or tissue donation or transplantation.
13. We may disclose your PHI of armed forces personnel if authorized by military command authorities. We

may also disclose your PHI to authorized federal officers for conducting national security, intelligence and counterintelligence activities.

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

Section 2. Rights of Individuals*Right to Request Restrictions on PHI Uses and Disclosures*

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

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

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

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

Right to Inspect and Copy PHI

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

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

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered

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

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

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

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

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

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

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

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

The Right to Receive an Accounting of PHI Disclosures

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

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

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

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

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

A Note About Personal Representatives

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

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you. Proof of such authority may take one of the following forms:

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

Right to Request Confidential Communications

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

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

Scott Marting
Director of Risk Management
100 Australian Avenue
West Palm Beach, Florida 33406

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

Right to Be Notified of a Breach

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

Section 3. The Plan's Duties

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

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

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

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

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

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;

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

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

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

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

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy officer: Tracy Ellison, Deputy County Administrator, 301 N Olive Ave, West Palm Beach, Florida 33401, (561) 233-2293. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

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

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

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

Conclusion

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

Questions

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

Tracy Ellison
Deputy County Administrator
301 N Olive Ave
West Palm Beach, FL 33401
Phone: (561) 355-2293
tjellison@pbc.gov

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment in Palm Beach County Board of County Commissioners' health plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you 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 after the marriage, birth, adoption, or placement for adoption.

Eligible employees and dependents may also enroll under two additional circumstances:

- The employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a subsidy (state premium assistance program). The employee or dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. To request special enrollment or obtain more information, contact Risk Management/Group Insurance at 561-233-5400.

Women's Health & Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

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, call your plan administrator [Risk Management/Group Insurance 561-233-5400].

Newborns' and Mothers' Health Protection 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 a 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).

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

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 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 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 askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in Florida, you may be eligible for assistance paying your employer health plan premiums. If you reside outside of Florida, view the entire CHIP Model Notice online at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.doc>. Contact your state for more information on eligibility.

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>

Phone: 1-877-357-3268

To locate the list of states, current as of July 31, 2026, or to view states that have recently added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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



New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

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

All employees. Eligible employees are:

- ☒ Some employees. Eligible employees are:

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

- With respect to dependents:

- ☒ We do offer coverage. Eligible dependents are:

Lawful spouse, domestic partner

Any child of the employee who is:

- 1) Less than 26 years old, or
- 2) From 26 years old until the end of the calendar year in which child reaches the age of 30, provided the child is unmarried and does not a dependent of their own, is a Florida state resident or a full-time or part-time student, and is not covered by a plan of their own or entitled to benefits under Title XVIII of the Social Security Act, or
- 3) 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under the health plan, or while covered as a dependent under a prior health plan with no break in coverage.
- 4) A child born to an insured Dependent child of the employee's until such child is 18 months old.
Find the full detail of dependent eligibility in your health plan summary plan description which is posted on the Board of County Commissioner's website.

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

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to

week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

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

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

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

☐ **Yes** (Continue)

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

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

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

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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

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

Important Notice from Palm Beach County Board of County Commissioners 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 Palm Beach County Board of County Commissioners 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. Palm Beach County Board of County Commissioners has determined that the prescription drug coverage offered by the Palm Beach County Board of County Commissioners Health Care 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, your current Palm Beach County Board of County Commissioners prescription drug coverage may be affected.

If you decide to join a Medicare drug plan and drop your current Palm Beach County Board of County Commissioners prescription drug 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 Palm Beach County Board of County Commissioners 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 Group Insurance Section of Risk Management (561)233-5400 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 Palm Beach County Board of County Commissioners 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: 10/15/2026
 Name of Entity/Sender: Palm Beach County Board of County Commissioners
 Contact-Position/Office: Group Insurance – Risk Management
 Address: 100 Australian Ave., Suite 200 – West Palm Beach, FL 33406
 Phone Number: (561)233-5400

IMPORTANT GENERAL NOTICE OF COBRA CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS

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

**** Continuation Coverage Rights Under COBRA****

This notice is intended to inform you of your rights and obligations under provisions of the COBRA law if you, your spouse and/or eligible dependents, if any, lose coverage due to a COBRA qualifying event in the future. It is important that you, your spouse and/or eligible dependents, if any, are aware of and understand your rights under COBRA. Please share this information with any family members that are covered under the employer's group benefit plan(s). Once again, this notice is for **informational purposes only**. Your benefits through Palm Beach County Board of County Commissioners have not been terminated or affected in any way.

Introduction

You're getting this notice because you recently gained coverage under the group health plan of Palm Beach County Board of County Commissioners. 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."

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 after the qualifying event occurs. You must provide this notice to your local Benefits Office.

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 Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify us of the fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. During the 11-month extension, you may be required to pay 150% of the premium. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify us of the fact within 30 days of SSA's determination.

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, Medicaid, 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.

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/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, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

Plan contact information

Palm Beach County Board of County Commissioners Group Health Plan

UnitedHealthcare
P.O. Box 740221
Atlanta, GA 30374
www.uhcservices.com

Customer Care Center
Toll Free: 1-866-747-0048 TTY 711
cobra_kyoperations@uhc.com

NOTICE REGARDING WELLNESS PROGRAM

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

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

Additional incentives of raffles prizes may be available for employees who participate in certain health-related activities such as educational seminars, fitness classes, wellness challenges, etc. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Kandace Smith Ezeilo at (561) 233-5447.

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

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to

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

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision.

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Kandace Smith Ezeilo at (561) 233-5447.

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2027 GUIDEBOOK



Disclaimer: This guide does not contain an exhaustive list of the terms and conditions of each benefit. Please refer to the policy, certificate of coverage, or the carrier for more information. Information contained herein does not constitute an insurance certificate or policy. Certificates or policies will be provided to participants following the start of the plan year, if applicable.



**2027 Group Insurance
Information**