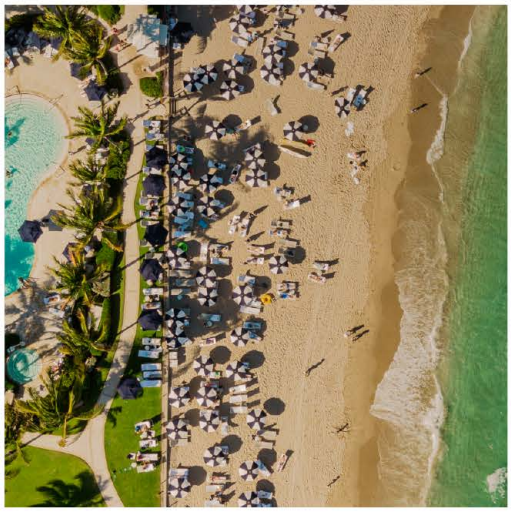
Capturing Joy,

One Click at a Time

PALM BEACH COUNTY

Board of County Commissioners

2025 Group Insurance Information



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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 Telephone: 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 Telephone: 561-841-4237 ♦ Email: palm-benefits@pbcgov.org
Palm Beach County Supervisor of Elections 4301 Cherry Road, West Palm
Online Benefits System for BCC and Palm Tran Employees: MyBenefits pbc.gov/MyBenefits

Insurance Carriers/Vendors

Benefit/Provider	Customer Service	Group Policy #
Medical: United Healthcare (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: Solstice Benefits, Inc. **www.solsticebenefits.com** (locate a provider) or www.mysmile365.com/Solstice (member portal)	855-494-0098 pbcgov@solsticebenefits.com	13000 BCC & Palm Tran 13001 SOE
Life Insurance: The Standard https://standard.benselect.com/palmbeach	800-779-0519	760741
Short- and Long-Term Disability: The Standard www.standard.com - Short-Term Disability - Long-Term Disability	800-779-0519 To file a claim online: www.standard.com “Find a Form” Select “Short-Term or Long Term” Disability Claim Packet (Outside NY)	760741
Flexible Spending Accts: 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
Solstice Discount Clear 100 Vision Plan (part of DENTAL (In-network plan only) **www.SolsticeBenefits.com**	855-494-0098	13000 BCC & Palm Tran 13001 SOE
Employee Assistant Program/EAP	561-233-5460	

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

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. Supervisor of Elections
Palm Beach County Supervisor of Elections Office
4301 Cherry Road
West Palm Beach, FL 33409
Telephone: 561-656-6200

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

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

Physical Well-Being The program hosts fitness opportunities year round. Activities are offered both in-person and virtually and may include 5K walk/run events, walking groups, yoga, Pilates, Zumba, and aqua-fit classes. All BCC employees and their UHC-insured dependents (ages 14+) are eligible. UHC insured members and their spouses/dependents over the age of 18 years old are eligible to join One Pass Select, a discounted gym network benefit. Access a number of gyms, live streaming videos, get at-home grocery delivery through Shipt, Walmart + and join AARP all for a monthly fee.	**Mental Well-Being** The program delivers mental and behavioral health education and resources to support employees' well-being. It empowers them to live fulfilling lives through workshops on stress management, selfcare, mindfulness, resilience, emotional intelligence, while also connecting them with Employee Assistance Program (EAP) for additional mental health support. Additionally, it engages employees in their mental health choices by offering both in-person and virtual workshops, including Mental Health First Aid and general well-being education.
Rally! Rally® is designed to help you take charge of your health by putting your benefits and resources in one place. Hitting your goals can be fun with personalized recommendations, as well as missions and challenges that may help make getting healthier more enjoyable. Plus, you can earn rewards along the way.	**Extra $$$ in your wallet!*** Participate in the "Be Well. Be Rewarded." program and earn up to $200 wellness incentive rewards each year. There are other opportunities to be rewarded such as the $30 for 30 fitness program, where you can receive $30 by visiting a fitness center 30 visits in the calendar year. It pays to be active. **For UHC-insured employees.*

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

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 with the **15th calendar day and ending on your 31st calendar day of employment.** 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 copied 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 **ISS 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. Your dependents will not be enrolled in the plans that you have elected for them, if the required information is not received. Such dependents will not be eligible for coverage until the next applicable 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.

ENROLLMENT GUIDE FOR NEW EMPLOYEES

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, The Standard.

If you do not complete the EOI process with The Standard, 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 The Standard at 1-800-779-0519 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 The Standard 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).

ENROLLMENT GUIDE FOR NEW EMPLOYEES

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.

BENEFITS RATES

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

Plan	Level of Coverage	Actual Cost	Monthly Employer Portion	Biweekly Employer Portion	Monthly Employee Portion	Biweekly Employee Portion
HMO	EE Only	$912.60	$881.60	$440.80	$31.00	$15.50
	EE + 1	$1,878.22	$1,677.22	$838.61	$201.00	$100.50
	EE + 2 or more	$2,567.20	$2,227.20	$1,113.60	$340.00	$170.00
	Overage Dep*	$548.00	$0.00	$0.00	$548.00	$274.00
CHOICE	EE Only	$951.08	$902.08	$451.04	$49.00	$24.50
	EE + 1	$1,952.22	$1,677.22	$838.61	$275.00	$137.50
	EE + 2 or more	$2,669.20	$2,227.20	$1,113.60	$442.00	$221.00
	Overage Dep*	$571.00	$0.00	$0.00	$571.00	$285.50
POS	EE Only	$1,007.12	$940.12	$470.06	$67.00	$33.50
	EE + 1	$2,037.84	$1,709.84	$854.92	$328.00	$164.00
	EE + 2 or more	$2,789.36	$2,288.36	$1,144.18	$501.00	$250.50
	Overage Dep*	$604.00	$0.00	$0.00	$604.00	$302.00

***Overage Dependent**: Additional amounts for each dep. age 26– 30 will be added to rates for other levels of coverage and 100% employee paid on a post- tax basis.

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

Plans	Solstice Basic DHMO S700B-PBC (Plan # 13123)		Solstice Low PPO (Plan # 11424)		Solstice High PPO (Plan # 11425)	
Level of Coverage	Monthly Cost	Biweekly Deduction	Monthly Cost	Biweekly Deduction	Monthly Cost	Biweekly Deduction
EE Only	$11.60	$5.80	$18.24	$9.12	$35.68	$17.84
EE + 1†	$19.82	$9.91	$34.62	$17.31	$68.40	$34.20
EE + 2†	$26.82	$13.43	$42.36	$21.18	$79.00	$39.50
EE + 3 or more	$35.44	$17.72	$58.82	$29.41	$111.76	$55.88

Plans	Solstice Enhanced DHMO S200B-PBC (Plan # 13122)		Solstice Premier PPO (Plan # 11426)	
Level of Coverage	Monthly Cost	Biweekly Deduction	Monthly Cost	Biweekly Deduction
EE Only	$14.88	$7.44	$44.22	$22.11
EE + 1†	$26.04	$13.02	$84.76	$42.38
EE + 2†	$32.24	$16.12	$97.92	$48.96
EE + 3 or more	$40.94	$20.47	$138.50	$69.25

BENEFITS RATES

FLEXIBLE SPENDING ACCOUNTS – P & A Administrative Services, Inc. - Contributions are based on 26 pay periods

- Healthcare FSA contributions: $260 min **$3,300** max annually or $10.00 **$126.92** bi-weekly
- Dependent Care FSA contributions: $260 min **$5,000** max annually or $10.00 min – **$192.31** bi-weekly

Term Life & AD&D Insurance/Additional Life & AD&D/Spouse Life & AD&D/Child Life –The Standard

- **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 the paycheck due to rounding

Coverage Amount	Bi-weekly Rate	Coverage Amount	Bi-weekly Rate	Coverage Amount	Bi-weekly Rate	SPOUSE Coverage Amount	Bi-weekly Rate
$10,000	$1.83	$210,000	$38.33	$410,000	$74.83	$5,000	$0.91
$20,000	$3.65	$220,000	$40.15	$420,000	$76.65	$10,000	$1.83
$30,000	$5.48	$230,000	$41.98	$430,000	$78.48	$15,000	$2.74
$40,000	$7.30	$240,000	$43.80	$440,000	$80.30	$20,000	$3.65
$50,000	$9.13	$250,000	$45.63	$450,000	$82.13	$25,000	$4.56
$60,000	$10.95	$260,000	$47.45	$460,000	$83.95	$30,000	$5.48
$70,000	$12.78	$270,000	$49.28	$470,000	$85.78	$35,000	$6.39
$80,000	$14.60	$280,000	$51.10	$480,000	$87.60	$40,000	$7.30
$90,000	$16.43	$290,000	$52.93	$490,000	$89.43	$45,000	$8.21
$100,000	$18.25	$300,000	$54.75	$500,000	$91.25	$50,000	$9.13
$110,000	$20.08	$310,000	$56.58			$55,000	$10.04
$120,000	$21.90	$320,000	$58.40			$60,000	$10.95
$130,000	$23.73	$330,000	$60.23			$65,000	$11.86
$140,000	$25.55	$340,000	$62.05			$70,000	$12.78
$150,000	$27.38	$350,000	$63.88			$75,000	$13.69
$160,000	$29.20	$360,000	$65.70			$80,000	$14.60
$170,000	$31.03	$370,000	$67.53			$85,000	$15.51
$180,000	$32.85	$380,000	$69.35			$90,000	$16.43
$190,000	$34.68	$390,000	$71.18			$95,000	$17.34
$200,000	$36.50	$400,000	$73.00			$100,000	$18.25

- **Child Life Coverage amounts of $5,000 and $10,000:** $5,000 coverage amount @ premium rate of $0.18 bi-weekly; $10,000 coverage amount @ $0.37 bi-weekly
- **Short Term Disability Insurance – The Standard** EE Only - Weekly benefit is 67% of gross/max $1,200/week. 100% employee paid $11.83 Bi-weekly Rate
- **Long Term Disability Insurance – The Standard 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 – The Standard Free Basic 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: Annual salary ÷ 12 months x .0046 - $4.30 = monthly ÷ 2 = bi-weekly rate
  - Employee without HMO/CHOICE: Annual salary ÷ 12 months x .0059 = monthly ÷ 2 = bi-weekly rate

Example: HMO/CHOICE EE @ $50,000/year will pay $7.43 bi-weekly ♦Non-HMO/Non-CHOICE EE @ $50,000 will pay $12.29 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 - UHC
- Dental Insurance - Solstice Benefits, Inc.
- Term life Insurance - The Standard
- Short-term Disability - The Standard
- Long-term Disability - The Standard
- 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.

ONLINE BENEFITS ENROLLMENT & INFORMATION SYSTEM - MYBENEFITS

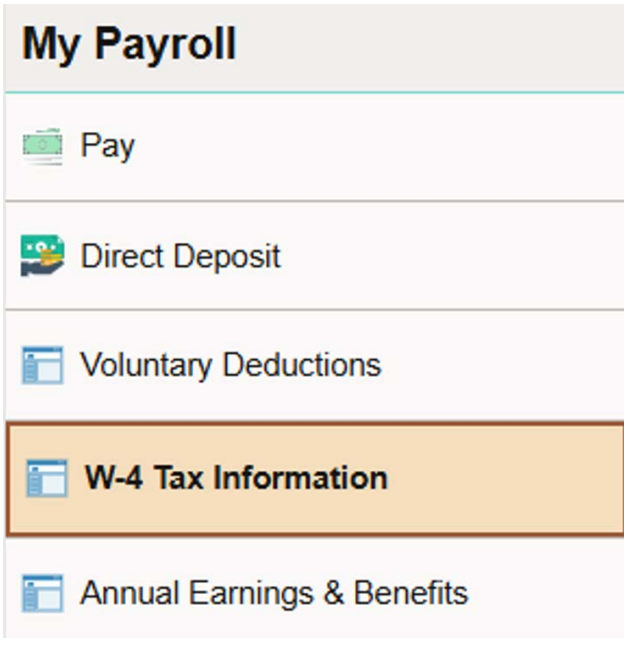
Online enrollment is the required method for Board of County Commissioners and Palm Tran employees to enroll for group insurance benefits. Supervisor of Election employees will receive enrollment instructions from their group insurance office or representative. Online enrollment allows you to have access 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.

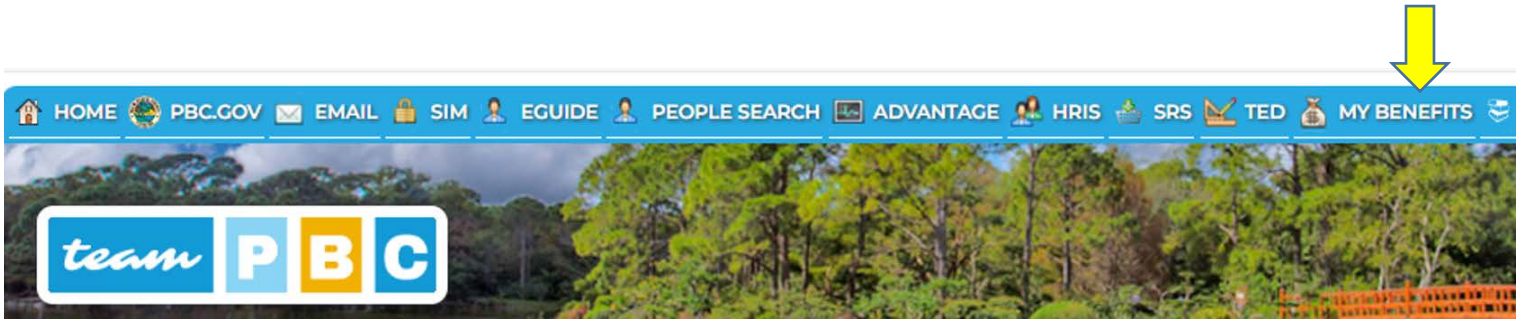
Other useful tasks you can accomplish in MyBenefits:

- 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*

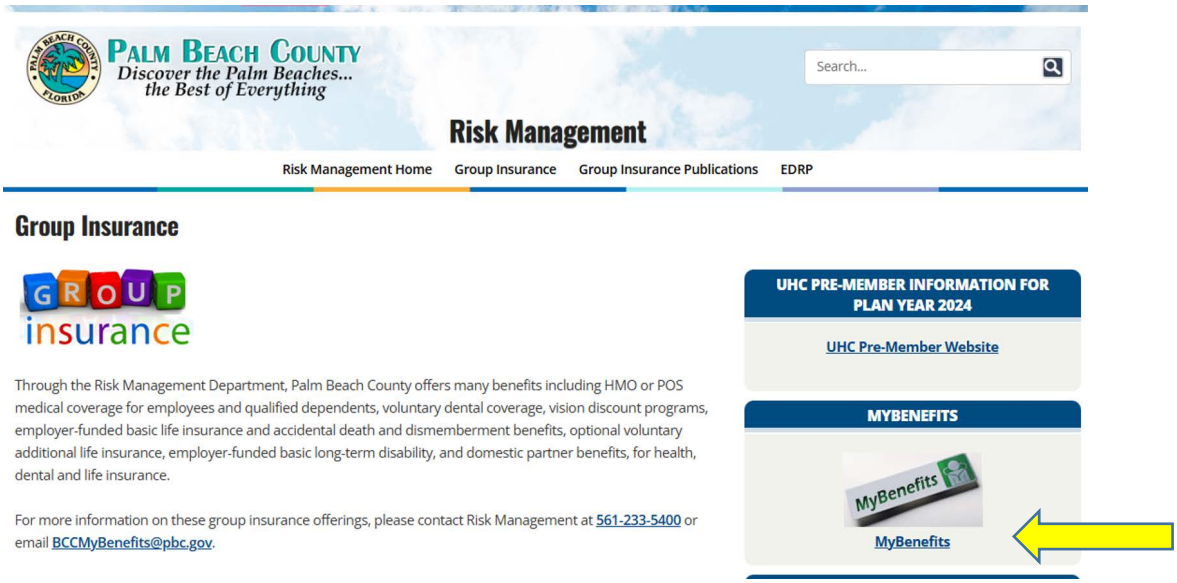


ACCESSING AND USING MYBENEFITS

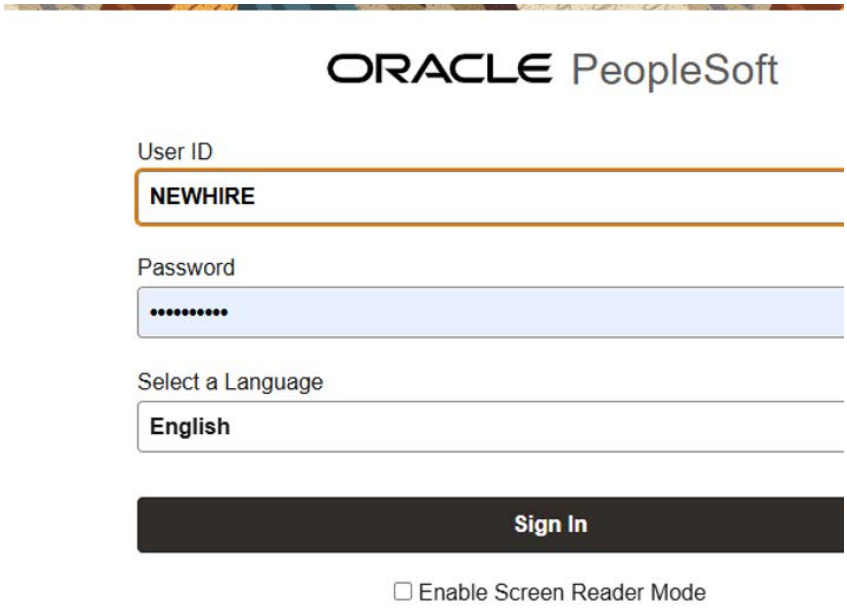
Step 1: Access **www.pbc./mybenefits**, Click on the link to MyBenefits from the County's intranet page, MyPBC



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":



ACCESSING AND USING MYBENEFITS

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

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, step-child, domestic partner child, foster child, child placed in your custody by a court order until the end of the month the child turns age 26 for medical, 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 fulltime or part-time student, and is not covered under a plan of their own or entitled to benefits under title XVIII of the Social Security Act) may be covered for medical and dental plans.

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

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

GROUP INSURANCE ELIGIBILITY

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.

GROUP INSURANCE ELIGIBILITY

- Some of the individuals who are NOT eligible to be covered as a dependent under an employee's group insurance plan, are parents (even if claimed as a dependent on an employee's tax return), siblings, as well as a former spouse. Non-qualified dependents cannot be covered/remain covered under the employee's group insurance plans. This applies even if a court order mandates that an employee must continue to pay for or cover the former spouse. Court ordered coverage for a former spouse would have to be elected from a source, other than the Board's group insurance program.

ELIGIBILITY DOCUMENTS

Refer to the following chart for required documentation:

Eligibility Categories	Required Documents:
• 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)
• Step child	• Executed, recorded marriage license/certificate of marriage to biological parent of child and birth certificate for child that names the employee's spouse as a parent
• Child of Domestic Partner	• Birth verification as indicated above, depending on type of child (biological, adopted, foster child, or child placed into custody of Domestic Partner by a court order) plus executed, notarized and recorded Declaration of Domestic Partnership form (Ord. 2006-002) **PLUS** • Proof partnership is still current (recurring monthly or quarterly household bill or statement of account listing partner's name at employee's address within the past 60 days)
Child 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
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 fulltime or part-time student status

ELIGIBILITY DOCUMENTS

Refer to the following chart for required documentation:

Eligibility Categories	**Required Documents:**
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.

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 DATE

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

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

Special enrollment due to 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.

Pre-Tax Benefit Plans

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

Payroll Deductions

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

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

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
- 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 BENEFITS

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 UNITED HEALTHCARE is the Secondary Plan
- If your Domestic Partner does not elect to enroll in Medicare Parts A and/or B when first eligible, the United Healthcare 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

Opt-Out Benefits

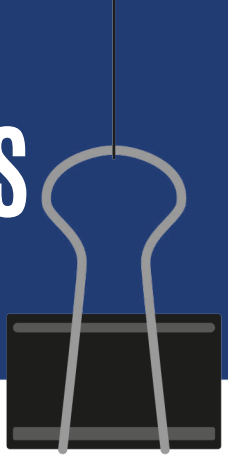
Employees may reject coverage for themselves and their dependents under the County's group medical plan if they are covered by another medical plan not funded by the Palm Beach County Board of County Commissioners. Employees who waive or "opt out" of the group medical plan receive a maximum $1,000 annual 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 INSURANCE

MEDICAL BENEFITS
UNITED HEALTHCARE



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

Plan	Level of Coverage	Actual Cost	Monthly Employer Portion	Biweekly Employer Portion	Monthly Employee Portion	Biweekly Employee Portion
HMO	EE Only	$912.60	$881.60	$440.80	$31.00	$15.50
	EE + 1	$1,878.22	$1,677.22	$838.61	$201.00	$100.50
	EE + 2 or more	$2,567.20	$2,227.20	$1,113.60	$340.00	$170.00
	Overage Dep*	$548.00	$0.00	$0.00	$548.00	$274.00
CHOICE	EE Only	$951.08	$902.08	$451.04	$49.00	$24.50
	EE + 1	$1,952.22	$1,677.22	$838.61	$275.00	$137.50
	EE + 2 or more	$2,669.20	$2,227.20	$1,113.60	$442.00	$221.00
	Overage Dep*	$571.00	$0.00	$0.00	$571.00	$285.50
POS	EE Only	$1,007.12	$940.12	$470.06	$67.00	$33.50
	EE + 1	$2,037.84	$1,709.84	$854.92	$328.00	$164.00
	EE + 2 or more	$2,789.36	$2,288.36	$1,144.18	$501.00	$250.50
	Overage Dep*	$604.00	$0.00	$0.00	$604.00	$302.00

***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://whyuhc.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.

MEDICAL BENEFITS

UNITED HEALTHCARE

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://whyuhc.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://whyuhc.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)

MEDICAL BENEFITS

UNITED HEALTHCARE

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://whyuhc.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

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 inquires
- ✓ And much more

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

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

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

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:
www.whyuhc.com/pbcbocc

MEDICAL BENEFITS

UNITED HEALTHCARE

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	
Benefits	**In-network Only**	**In-network Only**	**In-network**	**Out-of-network**
Physician services				
Office visit	Primary Care Physician You pay $20 per visit Specialist You pay $40 per visit	Primary Care Physician You pay $20 per visit Specialist You pay $40 per visit	Primary Care Physician You pay $20 per visit Specialist You pay $40 per visit	You pay 30% Plan pays 70% after the deductible is met
Preventive care				
Routine preventive care	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 BENEFITS

UNITED HEALTHCARE

Medical Plan Highlights continue

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Benefits	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

MEDICAL BENEFITS

UNITED HEALTHCARE

Medical Plan Highlights continue

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Benefits	**In-network Only**	**In-network Only**	**In-network**	**Out-of-network**
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 BENEFITS

UNITED HEALTHCARE

Medical Plan Highlights continue

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Benefits	**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

MEDICAL BENEFITS

UNITED HEALTHCARE

Medical Plan Highlights	Network (HMO)	CHOICE	Network POS	
Benefits	In-network Only	In-network Only	In-network	Out-of-network
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
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

MEDICAL BENEFITS

UNITED HEALTHCARE

Prescription Plan Highlights

Prescription Plan Highlights	Network (HMO)	CHOICE	Network POS	
Benefits	**In-network Only**	**In-network Only**	**In-network**	**Out-of-network**
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
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 BENEFITS
UNITED HEALTHCARE

Medical Benefit Exclusions

EXCLUSIONS

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

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the 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

MEDICAL BENEFITS

UNITED HEALTHCARE

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.

Go digital, get more out of your health plan benefits

Digital tools to keep you connected

Your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – give you access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Compare cost estimates before you get care, which may help you save money

Register once to access both tools

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

- Tap **Register Now** on the app, or select **Register** on the website
- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication – then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

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

Visit with a provider 24/7 — whenever, wherever

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

Another way to get care

Providers 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 permitted 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 and more

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

$0 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit — bringing a potential $2,000[4] cost down to $0.

Compare care options to help keep costs down

Getting care at the place that may best fit your condition or situation may save you up to $2,300 compared to an emergency room (ER) visit.* If you have a life-threatening condition, call 911 or go to the ER. For everything else, it may be best to contact your primary care provider (PCP) first. If seeing your PCP isn't possible, it's important to know your other care options, especially before heading to the ER.

START HERE

Care options to consider	PCP Care from the doctor who may know you best	24/7 Virtual Visits See a doctor whenever, wherever	Convenience care Basic conditions that aren't generally life-threatening	Urgent care Serious conditions that aren't generally life-threatening	Emergency room Life- and limb-threatening emergencies
Average cost*	**$165**	**Less than $49****	**$100**	**$185**	**$2,500**
Hours	**Varies by location**	**24/7**	**Varies by location**	**Varies by location—may be open nights/weekends**	**24/7**
How to connect	**Contact your PCP**	**myuhc.com/virtualvisits**	**myuhc.com®**	**myuhc.com**	**myuhc.com**
✔ **indicates the recommended place for care for the following common conditions:**					
Broken bone				✔	✔
Chest pain					✔
Cough	✔	✔	✔		
Fever	✔	✔	✔		
Muscle strain	✔		✔		
Pinkeye	✔	✔	✔		
Shortness of breath					✔
Sinus problems	✔	✔	✔		
Sore throat	✔	✔	✔		
Sprain	✔		✔	✔	
Urinary tract infection	✔	✔	✔		

Need to find a network provider or PCP? Visiting an out-of-network provider could end up costing you more for care. To find a PCP, urgent care centers and emergency rooms in your network, go to **myuhc.com**.
Not sure where to go for care? Call the number on your health plan ID card.

United Healthcare

Virtual care now includes additional specialists

Specialized care at your fingertips

Virtual care is accessible from anywhere on your schedule and is designed for affordability. With UnitedHealthcare, members have access to quality virtual specialists who may help you create a personalized care plan, eliminating the inconvenience of travel and waiting rooms.

Easy to access

Get a care plan from the comfort of your home, or anywhere on the go, through secure video, chat or email.

Works on your schedule

Request a visit and get care within a few days rather than months. Virtual care revolves around you — helping you find support when you need it, in a way that may work best for you.

Designed for affordable, quality care

Get access to care from specialists trained to understand your condition and deliver personalized care wherever you are.

With virtual care, access:

- Dermatology
- Gastroenterology
- Sleep
- Migraine care
- Speech therapy

And more

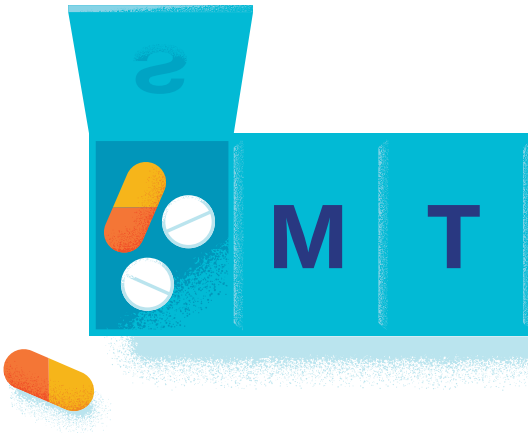
Get started

Go to **myuhc.com/virtualcare** to find the right care for you

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.

United Healthcare

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?

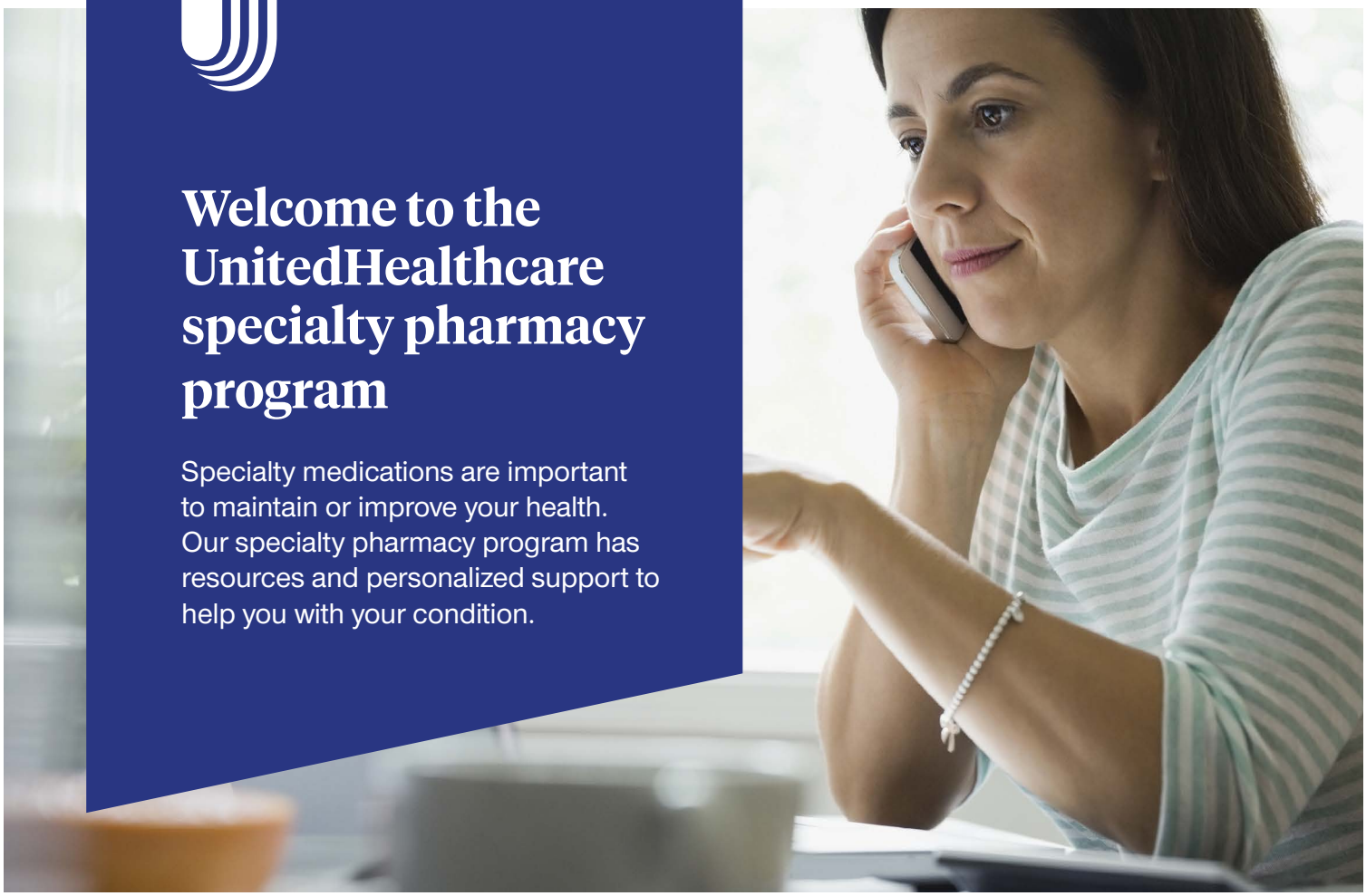
Call the number on the back of your member ID card to place your medication order and ask for the Easy Payment Plan. We'll split the cost for that order into 3 equal monthly payments that will be charged automatically to the payment method on file. When you make the first payment, we'll ship the entire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

United Healthcare



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

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

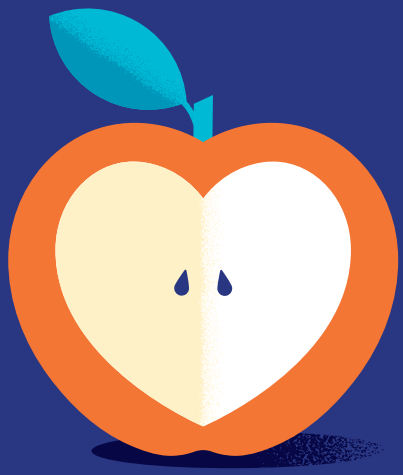
When you're sick and need care quick, a **24/7 Virtual Visit** is a convenient way to start feeling better faster. See and talk to a doctor via mobile device or computer - 24/7, no appointment needed. Access a 24/7 Virtual Visit via the UHC App or **myuhc.com.**

Learn more

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

United Healthcare

Your journey to a healthier lifestyle begins here



Welcome to Rally

Rally® is designed to help you take charge of your health by putting your benefits and resources in one place.

Hitting your goals can be fun with personalized recommendations, as well as missions and challenges that may help make getting healthier more enjoyable. Plus, you can earn rewards along the way.

1. Register and create your Rally profile

If you're a first-time user, create a username that's fun and memorable—but not your real name—and choose an avatar. If you're already a member, simply sign in.

2. Take the Health Survey

The Health Survey is designed to help you assess your overall health. You may use the results to help set your health goals.

3. Get personalized recommendations

Based on your Health Survey results, you'll receive personalized recommendations to help you live a healthier lifestyle—including well-being programs, everyday activities called missions and more.

4. Choose healthy activities to hit your goals

Take your pick of a wide variety of missions designed to help improve your fitness, diet and mood. Compete in challenges against friends or other members—or go for a personal best.

5. Get rewarded for healthy actions

Take healthy actions to achieve your goals and earn Rally Coins, which are redeemable for a variety of rewards.

6. Dive into communities

Interact with other members in a positive, friendly environment to get tips, motivation and support on everything from diet and fitness, to sleep, back pain and even relationships.

Visit myuhc.com® > Health Resources > Rally

United Healthcare | RALLY®

Healthier habits, healthier lifestyle

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

Get healthier, at no additional cost to you

Real Appeal on Rally Coach™ is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way

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

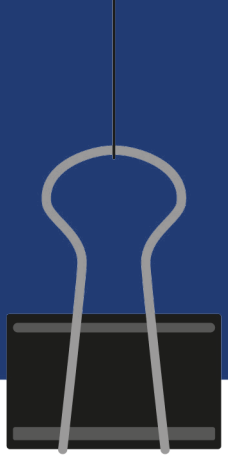
Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

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

United Healthcare | Real Appeal®

VISION BENEFITS
UNITED HEALTHCARE



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.

FLORIDA KIDCARE

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).

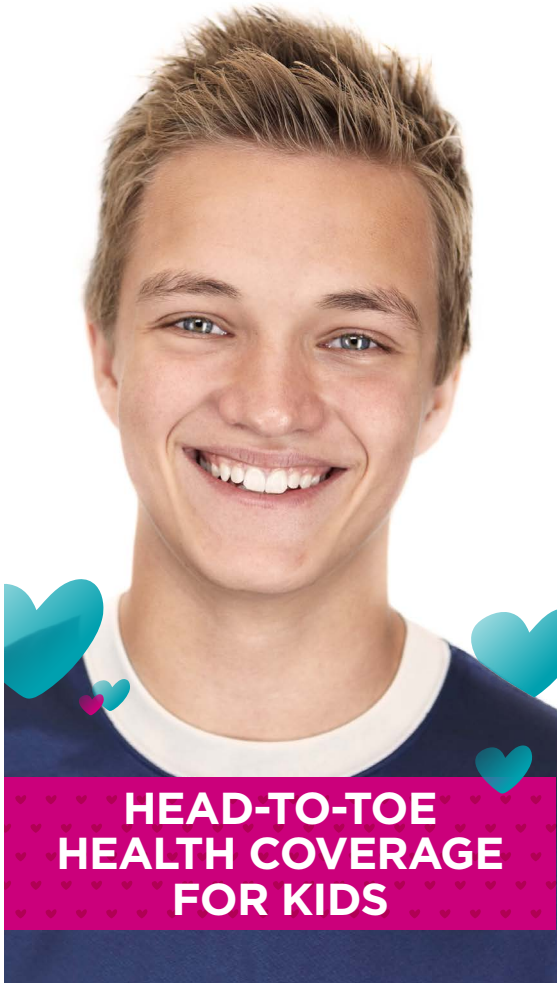
Florida KidCare
HEALTH AND DENTAL INSURANCE

HOW TO APPLY

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

2019

Florida KidCare
HEALTH AND DENTAL INSURANCE



DENTAL INSURANCE

Laura Wicks
Account Manager
lwicks@solsticebenefits.com

Solstice Dental Plan Summary

NOTE:
- Recommend when over $300 of dental work is suggested, the provider submit a claim to Solstice for predetermination prior to services being rendered for all 3 PPO plans.
- PPO Dental network is the same for all 3 PPO plans and is twice the size of the DHMO network

PPO Low (Plan number 11424)

- $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 (Plan number 11425)

- $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 (Plan number 11426)

- $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 S700B PBC Access+ (Plan number 13123)

DHMO Enhanced S200B PBC Access+ (Plan number 13122)

- 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.

Both DHMO Plans include:

- 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

DENTAL INSURANCE

Solstice Benefits, Inc.

A list of Limitations, Exclusions and Non-Covered Services are listed with at the end of the DHMO member schedule of benefits and with the PPO plan summaries.

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

Plans	Solstice Basic DHMO S700B-PBC (Plan # 13123)		Solstice Low PPO (Plan # 11424)		Solstice High PPO (Plan # 11425)	
Level of Coverage	**Monthly Cost**	**Biweekly Deduction**	**Monthly Cost**	**Biweekly Deduction**	**Monthly Cost**	**Biweekly Deduction**
EE Only	$11.60	$5.80	$18.24	$9.12	$35.68	$17.84
EE + 1†	$19.82	$9.91	$34.62	$17.31	$68.40	$34.20
EE + 2†	$26.82	$13.43	$42.36	$21.18	$79.00	$39.50
EE + 3 or more	$35.44	$17.72	$58.82	$29.41	$111.76	$55.88

Plans	Solstice Enhanced DHMO S200B-PBC (Plan # 13122)		Solstice Premier PPO (Plan # 11426)	
Level of Coverage	**Monthly Cost**	**Biweekly Deduction**	**Monthly Cost**	**Biweekly Deduction**
EE Only	$14.88	$7.44	$44.22	$22.11
EE + 1†	$26.04	$13.02	$84.76	$42.38
EE + 2†	$32.24	$16.12	$97.92	$48.96
EE + 3 or more	$40.94	$20.47	$138.50	$69.25

A list of Limitations, Exclusions and Non-Covered Services are listed with at the end of the DHMO member schedule of benefits and with the PPO plan summaries.

Solstice

Low PPO Plan 11424

Dental Plan Exclusively for PBC Board of County Commissioners

Dental PPO Summary of Benefits Effective 1/1/2025

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	$50	$100	$0	$0
Family Annual Calendar Year Deductible	$150	$300	$0	$0
Maximum *(the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)*	$1000 per person per Calendar Year	$500 per person per Calendar Year	$1000 per person per Lifetime	$1000 per person per Lifetime

Annual deductible applies to preventive and diagnostic services	Yes (In Network)	Yes (Out-of-Network)
Solstice Benefits*Booster* Included *(Increasing Calendar Year Maximum Benefit)*	Yes	
Preventive Waiver Saver Included *(P&D Services Do Not Accumulate Towards Annual Maximum)*	No	
Orthodontic eligibility requirement	Children up to 19 Years Old	

COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	80%	Limited to two (2) times per consecutive twelve (12) months.
Routine Radiographs	100%	80%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.
Non-Routine - Complete Series Radiographs	100%	80%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.
Prophylaxis (Cleanings)	100%	80%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.
Fluoride Treatment	100%	80%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.
Sealants	100%	80%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.
Space Maintainers	100%	80%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.
Palliative Treatment	100%	80%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit
BASIC SERVICES			
Restorations (Amalgam or Composite)	70%	50%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	70%	50%	Limited to one (1) time per tooth per lifetime.
MAJOR SERVICES			
Anesthetics	40%	20%	General Anesthesia: When clinically necessary.
Adjunctive Services	40%	20%	
Oral Surgery (includes surgical extractions)	40%	20%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics - Surgical	40%	20%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.
Periodontics - Non Surgical	40%	20%	Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.
Endodontics	40%	20%	
Inlays/Onlays/Crowns	40%	20%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	40%	20%	Full Denture/Partial Denture/Bridges: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	40%	20%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	25%	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.

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

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

Solstice

High PPO Plan 11425

Dental Plan Exclusively for PBC Board of County Commissioners

Dental PPO Summary of Benefits Effective 1/1/2025

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	$50	$100	$0	$0
Family Annual Calendar Year Deductible	$150	$300	$0	$0
Maximum *(the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)*	$1500 per person per Calendar Year	$1000 per person per Calendar Year	$1000 per person per Lifetime	$1000 per person per Lifetime

Annual deductible applies to preventive and diagnostic services	No (In Network)	No (Out-of-Network)
Solstice Benefits*Booster* Included *(Increasing Calendar Year Maximum Benefit)*	Yes	
Preventive Waiver Saver Included *(P&D Services Do Not Accumulate Towards Annual Maximum)*	No	
Orthodontic eligibility requirement	Adults and Children	

COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	90%	Limited to two (2) times per consecutive twelve (12) months.
Routine Radiographs	100%	90%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.
Non-Routine - Complete Series Radiographs	100%	90%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.
Prophylaxis (Cleanings)	100%	90%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.
Fluoride Treatment	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.
Sealants	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.
Space Maintainers	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.
Palliative Treatment	100%	90%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit
BASIC SERVICES			
Restorations (Amalgam or Composite)	80%	70%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	80%	70%	Limited to one (1) time per tooth per lifetime.
MAJOR SERVICES			
Anesthetics	50%	40%	General Anesthesia: When clinically necessary.
Adjunctive Services	50%	40%	
Oral Surgery (includes surgical extractions)	50%	40%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics - Surgical	50%	40%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.
Periodontics - Non Surgical	50%	40%	Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.
Endodontics	50%	40%	
Implants	50%	40%	Subject to separate Lifetime Maximum of $2,500
Inlays/Onlays/Crowns	50%	40%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	50%	40%	Full Denture/Partial Denture/Bridges: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	50%	40%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.

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

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

Solstice

PPO Premier Plan 11426

Dental Plan Exclusively for PBC Board of County Commissioners

Dental PPO Summary of Benefits Effective 1/1/2025

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Individual Annual Calendar Year Deductible	$50	$50	$0	$0
Family Annual Calendar Year Deductible	$150	$150	$0	$0
Maximum *(the sum of all Network and Out-of-Network benefits will not exceed Maximum Benefits)*	$3500 per person per Calendar Year	$3500 per person per Calendar Year	$2000 per person per Lifetime	$2000 per person per Lifetime

Annual deductible applies to preventive and diagnostic services	No (In Network)	No (Out-of-Network)
Solstice Benefits*Booster* Included *(Increasing Calendar Year Maximum Benefit)*	No	
Preventive Waiver Saver Included *(P&D Services Do Not Accumulate Towards Annual Maximum)*	No	
Orthodontic eligibility requirement	Adults and Children	

COVERED SERVICES	NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	90%	Limited to two (2) times per consecutive twelve (12) months.
Routine Radiographs	100%	90%	Bitewings: Limited to one (1) series of films per consecutive twelve (12) months.
Non-Routine - Complete Series Radiographs	100%	90%	Complete Series/Panorex: Limited to one (1) time per consecutive thirty-six (36) months.
Prophylaxis (Cleanings)	100%	90%	Limited to (2) prophylaxis in any twelve (12) consecutive months, to a maximum of (2) total prophylaxis and periodontal maintenance procedures in any twelve (12) consecutive months.
Fluoride Treatment	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per consecutive twelve (12) months.
Sealants	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, and to one (1) time per first or second unrestored permanent molar every consecutive thirty-six (36) months.
Space Maintainers	100%	90%	Limited to Covered Persons under the age of sixteen (16) years, one (1) time per consecutive sixty (60) months. Benefit includes all adjustments within six (6) months of installation.
Palliative Treatment	100%	90%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit
BASIC SERVICES			
Restorations (Amalgam or Composite)	80%	70%	Multiple restorations on one (1) surface will be treated as a single filling.
Simple Extractions	80%	70%	Limited to one (1) time per tooth per lifetime.
MAJOR SERVICES			
Oral Surgery (includes surgical extractions)	50%	40%	Extractions: Limited to one (1) time per tooth per lifetime.
Periodontics - Surgical	50%	40%	Periodontal Surgery: Limited to one (1) quadrant or site per consecutive thirty-six (36) months per surgical area.
Periodontics - Non Surgical	50%	40%	Scaling and Root Planing: Limited to one (1) time per quadrant per consecutive twenty-four (24) months. Periodontal Maintenance: Limited to two (2) periodontal maintenance in any twelve (12) consecutive months, to a maximum of two (2) total prophylaxis and periodontal maintenance procedures in any twelve(12) consecutive months.
Endodontics	50%	40%	
Anesthetics	50%	40%	General Anesthesia: When clinically necessary.
Adjunctive Services	50%	40%	
Implants	50%	40%	Subject to separate Lifetime Maximum of $2,500
Inlays/Onlays/Crowns	50%	40%	Limited to one (1) time per tooth per consecutive sixty (60) months.
Dentures and other Removable Prosthetics	50%	40%	Full Denture/Partial Denture/Bridges: Limited to one (1) per consecutive sixty (60) months. No additional allowances for precision or semi precision attachments.
Fixed Partial Dentures (Bridges)	50%	40%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Limited to no more than twenty-four (24) months of treatment, with the initial payment of 20% at banding and remaining payment prorated over the course of treatment.

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

**Out of-Network benefits are based on the 90th Percentile of Usual and Customary Charge.

Limitations, Non-Covered Services, and Exclusions

General Limitations

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

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

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

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

DENTAL PROPHYLAXIS (CLEANINGS) are limited to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Covered Services

The following are NOT covered under the plan:

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

Exclusions

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

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

Solstice Benefits*Booster*

What is Benefits*Booster*?

Benefits*Booster* is an Increasing Calendar Year Maximum feature included in select Solstice dental plans that puts dental care decisions directly in the hands of the consumer. Members are encouraged to seek care through an awards-based framework that allows them to carry forward part of their unused calendar year maximum.

Highlights of the Solstice Benefits*Booster*

- No penalty if dental services are not used in the year
- Carry forward unused balances
- Competitor's award balance accepted
- Award balance may be used for out-of-network claims

How does Benefits*Booster* work?

Benefits*Booster* is designed for dental plans with deductibles and annual maximums and can be utilized by groups who are either fully insured or ASO. It is administered at the member level, giving each member an opportunity to earn their own awards. Members must use their dental benefit at least once per year, and can qualify for an additional bonus if a member utilizes all in network providers.

Maximum Benefit	Claim Threshold	Carryover Amount	Network Bonus	Increase Limit	Maximum Benefit Limit
$500	$250	$125	$100	$500	$1,000
$1,000	$500	$250	$100	$1,000	$2,000
$1,250	$500	$250	$100	$1,250	$2,500
$1,500	$750	$400	$100	$1,500	$3,000
$2,000	$1,000	$500	$100	$1,500	$3,500
$2,500	$1,250	$600	$100	$1,875	$4,375
$3,000	$1,500	$700	$100	$2,250	$5,250

There are some limitations to the program:

- New groups sold, and new hires made, in the last three months of the benefit period (October, November or December) will have participation deferred until the 1st month of the next full benefit period
- If a member chooses to terminate coverage, but returns prior to a six-month break in coverage with the same employer, participation will be reinstated without penalty or loss of any previously accumulated award balance, provided the employer still offers a dental plan with Benefits*Booster*. Award balance is considered depleted once the six-month window has passed or when consumer purchases another plan without the Benefits*Booster* feature.

MYSMILE365 BENEFITS PORTAL

www.mysmile365.com

As a Solstice member, you and your family will be able to securely log into the MySmile365 member portal and have complete access to your benefits

Take a look at a few of the capabilities the member portal offers:

- Access your plan benefits information
- View any previously filed claims or oustanding claim statuses
- Use the provider search tool to find a provider in your area
- And more!

Not using your MySmile365 member portal yet?
Sign up - it's easy!

1. Visit **www.mysmile365.com** and click "register"
2. The system will then display the member verification page.
3. Enter your membership information and click "continue".
4. The system will display your account creation page to create your username and password. Enter your information.
5. Once complete review and select that you agree to terms and conditions and click enter account.

*Need help? We're here for you! Conact our customer care team at **1-877-760-2247***
Monday through Friday from 8:00 am - 8:00 pm ET

SOLSTICE MEMBER PERKS

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

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

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

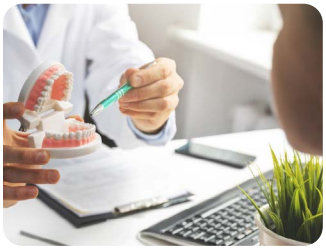
Women in their 2nd or 3rd trimester of pregnancy can receive additional cleanings at no cost. Just let your dentist know that you're pregnant, your due date, attending doctor's name, and your Solstice network provider will submit your claim.

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

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

Dental PPO Rollover Benefits

Visiting your dentist on a regular basis positively affects your overall health and your pocket. Another way it benefits you is that by using your dental plan at least once for the year, you may qualify for Solstice's dental rollover program, the Benefits*Booster*. This increasing calendar maximum feature allows you to carry forward part of your unused calendar year maximum from year to year.



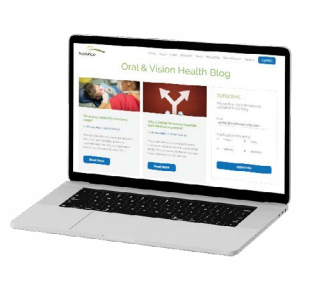
Implant Services - *Pay discounted fees on 30 implant procedures*

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

contact@solsticebenefits.com www.solsticebenefits.com 1.877.760.2247

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

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

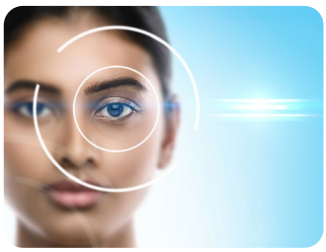


Educational Resources - *Understanding benefits through award-winning resources*

We are passionate about helping you understand your benefits. Become a boss at understanding your coverage through our award-winning website (www.solsticebenefits.com). It includes our blog that addresses a wide range of dental and vision topics, our quarterly newsletter, and access to helpful online resources such as your Dental Scorecard and Healthy Tips Library.

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

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



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

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

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

Need an additional pair of glasses but it's only covered every 12 months. Could you use an extra supply of contacts? Take advantage of our Clear 100 vision value add-on, and receive discounts on materials or services not covered by your vision insurance.

SOLSTICE VISION BENEFITS

Clear Vision 100 Discount Vision Plan

DISCOUNT PRESCRIPTION PLAN

An added value at no cost to you.

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

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

Save an average of 50%
on generic medication when you order by mail.

Save an average of 20%
on brand and generic medication when visiting a participating pharmacy.

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

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

BENEFITS

Plan Highlights

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

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

This Plan is not insurance. This Plan provides discounts at certain providers for vision services. The plan does not make payments directly to the providers of the vision service. The member is obligated to

pay for all vision care services but will receive a discount from those providers who have contracted with the discount plan organization.

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

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

Members can choose a participating Solstice Clear Vision provider at

www.SolsticeBenefits.com or contact Member Services at 877-760-2247 for a printed copy.

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

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 doctors usual fees
Frames	33% discount off of doctors usual fees
Contact Lenses	
• Fitting & Evaluation	20% discount
• Contact Lenses	
• Contact Lens Replacement	
(Includes care kit, insertion and removal instruction, routine follow-up/6 months)	

Solstice

SOLSTICE RETAIL VISION CHAINS

Take a gander at our retail connections

America's Best Contacts & Eyeglasses

Brevard Eye Center

Eyeglass World®

For Eyes®

Frantz EyeCare

College of Optometry
NOVA SOUTHEASTERN UNIVERSITY
NSU Florida
THE EYECARE INSTITUTE

opti-mart
Family Owned & Operated Since 1988

Sam's Club

South Florida Vision

Stanton Optical

Walmart

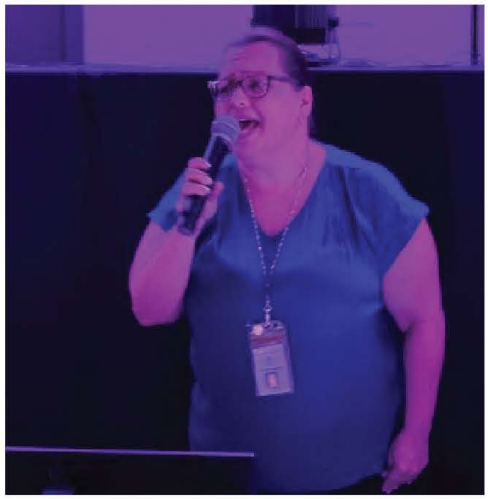
my eye lab

Visionworks

myeyeDr.

Eye Doctor's Optical Outlets
Your Best Buy In Sight

Eye Centers of Florida
CLEARLY THE RIGHT CHOICE
SINCE 1971



LIFE INSURANCE

LIFE INSURANCE

The Standard

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: Life insurance beneficiaries are managed solely by the life insurance carrier. Beneficiary declarations are only effective if they were made directly with the life insurance carrier. Declare your beneficiaries for your basic and any supplemental group term life coverage directly with The Standard by visiting Ready Enroll at https://standard.benselect.com/palmbeach. When a death claim is filed with The Standard, the following steps will be followed for confirmation of beneficiaries on file.

1. Proceeds will be paid to beneficiaries declared by the employee with The Standard.
2. If the employee did not declare a beneficiary with The Standard, life insurance proceeds will be paid to declared beneficiaries referenced in the extracted beneficiary data provided by the prior carrier, Securian Financial.
3. If the employee did not declare their beneficiary in The Standard's beneficiary system, Ready Enroll, and no beneficiary data was found in the prior carrier's file, then life insurance proceeds will be paid by policy order in accordance with the life insurance Group Policy.

It is critical that every benefits eligible employee visits Ready Enroll and updates their desired life insurance beneficiaries.

GROUP BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by paid by your employer.

Eligibility

Definition of a Member	You are a member if you are a regular permanent employee of the Board of County Commissioners, Supervisor of Elections or Palm Tran, Inc., who is actively at work at least 30 hours per week. You are not a member if you are a Palm Beach County Fire Rescue member and a member of the Professional Fire Fighters of Palm Beach County IAFF Local 2928, Palm Beach County Sheriff's Office, Tax Collector, Property Appraiser, Clerk of the Court, temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Active members
Eligibility Waiting Period	If you are already a member on the date the group policy is effective, you are eligible on that date. If you become a member after the group policy effective date, you are eligible on the first day of the month that follows or coincides with 60 days as a member.

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $25,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is $15,000. For other covered losses, a percentage of this benefit will be payable.

Benefits **Continued**

Age Reductions	Basic Life and AD&D insurance coverage amounts reduce to 50% at age 70.

Other Basic Life Features and Services

- Accelerated Death Benefit
- Life Services Toolkit
- Portability of Insurance
- Repatriation Benefit
- Right to Convert
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag and Seat Belt Benefit
- Family Benefits Package (includes Career Adjustment, Child Care, and Higher Education Benefits)
- Helmet Benefit

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by Palm Beach County Board of County Commissioners. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, exclusions and when The Standard and Palm Beach County Board of County Commissioners may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

standard.com

760741-C1

GROUP ADDITIONAL LIFE AND AD&D INSURANCE FOR PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS

We can help provide for your family when you can't.

Group Additional Life and Accidental Death and Dismemberment (AD&D) insurance can help protect your family's finances if something happens to you. This coverage can help provide financial support and stability to your family if you pass away or have a serious accident.

Additional Life and AD&D insurance can help make things easier for the people you care about.

Life insurance helps protect the people who depend on your income by paying them an amount of money specified in the policy if you die.

AD&D insurance pays an amount of money specified in the policy if a covered accident results in your death or a severe physical loss, such as a hand, a foot or your eyesight.

Life and AD&D insurance is an easy, responsible way to help your loved ones during a difficult time — and into the future.

What's at stake.

A death or serious accident might leave your family facing expenses they couldn't cover without your income. That could include extra costs for medical care or a funeral.

You're covered under Basic Life insurance if you take no action, provided you meet the eligibility requirements. But if Basic Life insurance doesn't meet your needs, you can apply for additional coverage. **Plan now to help your family cover future expenses, such as:**

Tuition

Child Care

Housing Costs

Daily Living Expenses

Life Insurance

How Much Can I Apply For?

The coverage amount for your spouse/domestic partner (DP) cannot exceed 100% of your combined Basic and Additional Life coverage.

The coverage amount for your child(ren) cannot exceed 100% of your combined Basic and Additional Life coverage.

For You:
$10,000 – $500,000 in increments of $10,000

For Your Spouse/DP:
$5,000 – $100,000 in increments of $5,000

For Your Child(ren):
Option 1: $5,000
Option 2: $10,000

What Is The Guarantee Issue Amount?

Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.

For You:
Up to $300,000

For Your Spouse/DP:
Up to $50,000

What Does My AD&D Benefit Provide?

For You:
The AD&D insurance coverage amount matches what you elect for Additional Life insurance.

For Your Spouse/DP:
The AD&D insurance coverage amount matches what you elect for Dependents Life insurance.

Keep in mind that the amount payable for certain losses is less than 100% of the AD&D Insurance benefit.

See the Important Details section for more information, including requirements, exclusions, limitations, age reductions and definitions.

Open Enrollment

During Open Enrollment From October 22, 2024 Through November 5, 2024:

For You. If you are currently enrolled in Additional Life insurance for an amount less than $300,000, you may elect to increase your coverage up to, but not to exceed, the guarantee issue amount of $300,000 without having to answer health questions. If you are not currently enrolled in Additional Life insurance, you may elect coverage up to the guarantee issue amount of $300,000 without having to answer health questions.

For Your Spouse/DP. If your spouse/DP is currently enrolled in Dependents Life insurance for an amount less than $50,000, you may elect to increase coverage up to, but not to exceed, the guarantee issue amount of $50,000 without having to answer health questions. If your spouse/DP is not currently enrolled in Dependents Life insurance, you may elect coverage up to the guarantee issue amount of $50,000 without having to answer health questions.

Additional Feature

Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 100% of your combined Basic and Additional Life benefit to a maximum of $500,000.

How Much Your Coverage Costs

Your Basic Life insurance is paid for by Palm Beach County Board of County Commissioners. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck.

How much your premium costs depends on the benefit amount. If you buy Additional Life and AD&D insurance, your semi-monthly rate for this coverage is $0.1825 per $1,000 of coverage. Premium for this coverage will be deducted directly from your paycheck.

Employee Life Semi-Monthly Premiums*

Coverage Amount	Semi-monthly premium	Coverage Amount	Semi-monthly premium
$10,000	$1.83	$260,000	$47.45
$20,000	$3.65	$270,000	$49.28
$30,000	$5.48	$280,000	$51.10
$40,000	$7.30	$290,000	$52.93
$50,000	$9.13	$300,000	$54.75
$60,000	$10.95	$310,000	$56.58
$70,000	$12.78	$320,000	$58.40
$80,000	$14.60	$330,000	$60.23
$90,000	$16.43	$340,000	$62.05
$100,000	$18.25	$350,000	$63.88
$110,000	$20.08	$360,000	$65.70
$120,000	$21.90	$370,000	$67.53
$130,000	$23.73	$380,000	$69.35
$140,000	$25.55	$390,000	$71.18
$150,000	$27.38	$400,000	$73.00
$160,000	$29.20	$410,000	$74.83
$170,000	$31.03	$420,000	$76.65
$180,000	$32.85	$430,000	$78.48
$190,000	$34.68	$440,000	$80.30
$200,000	$36.50	$450,000	$82.13
$210,000	$38.33	$460,000	$83.95
$220,000	$40.15	$470,000	$85.78
$230,000	$41.98	$480,000	$87.60
$240,000	$43.80	$490,000	$89.43
$250,000	$45.63	$500,000	$91.25

*Coverage amounts for ages 70 and over reduce due to age reduction

How Much Life Insurance Do You Need?

After a serious accident or death in the family, there are many unexpected expenses.

Your benefits could help your family pay for:

- Outstanding debt
- Your child(ren)'s education
- Burial expenses
- Daily expenses
- Medical bills

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **standard.com/life/needs**.

How Much Your Coverage Costs continued

Spouse Life Semi-Monthly Premiums

If you buy Additional Life and AD&D insurance for your spouse/DP, your semi-monthly rate is $0.1825 per $1,000 of coverage.

Coverage Amount	Semi-monthly premium
$5,000	$0.91
$10,000	$1.83
$15,000	$2.74
$20,000	$3.65
$25,000	$4.56
$30,000	$5.48
$35,000	$6.39
$40,000	$7.30
$45,000	$8.21
$50,000	$9.13
$55,000	$10.04
$60,000	$10.95
$65,000	$11.86
$70,000	$12.78
$75,000	$13.69
$80,000	$14.60
$85,000	$15.51
$90,000	$16.43
$95,000	$17.34
$100,000	$18.25

*Coverage amounts for ages 70 and over reduce due to age reduction

Dependent Life Semi-Monthly Premiums

If you buy Dependent Life insurance for your child(ren), your semi-monthly rate is $0.0365 per $1,000 of coverage, no matter how many children you're covering.

Coverage Amount	Semi-monthly premium
$5,000	$0.18
$10,000	$0.37

Important Details

Here's where you'll find the details about the plan.

Life and AD&D Insurance Eligibility Requirements

To be eligible for coverage, you must be:

- Insured for Basic Life insurance through The Standard
- A regular permanent employee of the Board of County Commissioners, Supervisor of Elections or Palm Tran, Inc., who is actively at work at least 30 hours per week

Palm Beach County Fire Rescue who are members of Professional Fire Fighters of Palm Beach County IAFF Local 2928, Palm Beach County Sheriff's office, Tax Collector, Property Appraiser, Clerk of the Court, temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

If you buy Additional Life and AD&D insurance for yourself, you may also buy Life and AD&D coverage for your eligible spouse/DP. You may buy Life coverage for your eligible child(ren). This is called Dependents insurance.

You can choose to cover your spouse/DP, meaning a person to whom you are legally married, or your domestic partner as recognized by law. **You cannot be insured as both an individual and a spouse/DP.**

You may also choose to cover your child. Child means your child from live birth through the last day of the calendar month in which your child reaches age 26. Please note:

- Your child cannot be insured by more than one employee.
- Your spouse/DP or child(ren) must not be a full-time member(s) of the armed forces.
- You cannot be insured as both an individual and a child.

Medical Underwriting Approval for Life Coverage

Required for:

- Coverage amounts higher than the guarantee issue amount
- All late applications for employee and spouse/DP (applying 31 days after becoming eligible)
- Requests for coverage increases for an employee or spouse/DP
- Reinstatements
- Employees and spouses eligible but not insured under the prior life insurance plan

Note:

- Medical underwriting is not required for child(ren).
- If your family status changes, you may have the ability to apply for coverage or increase your coverage for a limited time without having to submit a Medical History Statement. Please see your Group Insurance representative for more information.

Coverage Effective Date for Life Coverage

To become insured, you must:

- Meet the eligibility requirements listed in the previous sections
- Serve an eligibility waiting period*
- Receive medical underwriting approval (if applicable)
- Apply for coverage and agree to pay premium
- Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective

*If you are already a member on the date the group policy is effective, you are eligible on that date. If you become a member after the group policy effective date, you are eligible on the first day of the month that follows or coincides with 60 consecutive days as a member.

If you are not actively at work on the day before the scheduled effective date of your insurance, including any Dependents Life insurance coverages, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee. You may have a different effective date for Life coverage below and above the guarantee issue amount. Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your insurance, including Dependents Life insurance.

Life and AD&D Age Reductions

Under this plan, your coverage amount reduces to 50% at age 70. Your spouse/DP's coverage is not subject to reductions due to age.

Life Insurance Waiver of Premium

Your Life premiums may be waived if you:

- Become totally disabled while insured under this plan
- Are under age 60
- Complete a waiting period of 180 days

If these conditions are met, your Life insurance coverage may continue without cost until Social Security Normal Retirement Age, provided you give us satisfactory proof that you remain totally disabled.

Life and AD&D Insurance Portability

If your insurance ends because your employment terminates or you retire under the employer's retirement plan, you may be eligible to buy portable group insurance coverage from The Standard.

Life Insurance Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

AD&D Benefits

The amount of the AD&D benefit is equal to the amount payable for your or your spouse/DP's Life benefit on the date of the accident. For all other covered losses, the amount is shown as a percentage of the amount payable for the benefit on the date of the accident. No more than 100% of the AD&D benefit will be paid for all losses resulting from one accident.

Any loss must be caused solely and directly by an accident within 365 days of the accident. A certified copy of the death certificate is needed to prove loss of life.

All other losses must be certified by a physician in the appropriate specialty determined by The Standard.

Covered Loss	Percentage of AD&D Payable Benefit
Life[1]	100%
One hand or one foot[2]	50%
Sight in one eye, speech or hearing in both ears	50%
Two or more of the losses listed above	100%
Thumb and index finger of the same hand[3]	25%
Quadriplegia	100%
Hemiplegia	50%
Paraplegia	75%
Triplegia	75%
Uniplegia	25%

1 Includes loss of life caused by accidental exposure to adverse weather conditions or disappearance if disappearance is caused by an accident that reasonably could have resulted in your death.

2 Even if the severed part is surgically re-attached. This benefit is not payable if an AD&D benefit is payable for quadriplegia, hemiplegia, paraplegia or uniplegia or triplegia involving the same hand or foot.

3 This benefit is not payable if an AD&D benefit is payable for the loss of the entire hand.

AD&D Insurance Exclusions

You are not covered for death or dismemberment caused or contributed to by any of the following:

- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Suicide or other intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared), and any substantial armed conflict between organized forces of a military nature
- Voluntary consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The last day of the calendar month in which your employment terminates
- The last day of the calendar month in which you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy
- The date your Life coverage ends, your AD&D coverage will end as well

In addition to the above requirements, your Dependents Life with AD&D coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent.

For more details on when your insurance ends, contact your Group Insurance representative.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information presented in this summary does not modify the group policy, certificate or the insurance coverage in any way.

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

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

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

GP190-LIFE/S399, GP399-LIFE/TRUST, GP899-LIFE, GP190-LIFE/A997/S399, GP411-LIFE, GP190-LIFE/S214

ALAA-760741-C1
SI **20347** (10/24)

Group Life Insurance Beneficiary Designation FAQs

These are commonly asked questions about beneficiary designations under the Group Life Insurance Policy issued by Standard Insurance Company (The Standard). The Standard administers claims for life insurance benefits in accordance with the Group Policy terms and makes the ultimate decision on claim payments. The Group Policy terms supersede any discrepancy between these FAQs and the Group Policy. Please refer to your Group Life Insurance Certificate and Summary Plan Description or Certificate for the policy terms.

These FAQs are for informational purposes and do not serve as legal advice. As with any other legal matter, The Standard recommends that you consult with your legal advisor.

Can I name more than one person as my beneficiary?

Yes. You may name as many persons as you wish. The beneficiary designation form typically allows room for you to name the number of beneficiaries you want and the percentage of the life insurance benefits you want to leave for each beneficiary. If you do need more room, remember to sign and date any additional designations that you attach to the form.

Why should I name a beneficiary for my life insurance?

If you do not name a beneficiary, The Standard will pay the life insurance benefits according to the policy order. Typically, that means your surviving spouse would be paid the benefits as the first person listed in the order; if none, then the benefits would be paid, in equal shares, to your surviving children; if none, then to your parents; if none, then to your siblings; if none, then to your estate. The same process would be followed if your designated beneficiary is no longer living at the time of your death, unless you have named a contingent beneficiary.

What is a contingent beneficiary?

A contingent beneficiary is the person you may name to receive your life insurance benefits if your primary beneficiary is no longer living at the time of your death. If you do not name a contingent beneficiary and your designated beneficiary is no longer living at the time of your death, then The Standard typically will pay the life insurance benefits according to the policy order, as described above.

Do I have to name my spouse as beneficiary?

No. The Group Policy is written to allow you to designate anyone you want as your beneficiary.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

www.standard.com

Do I have to name my spouse as beneficiary for a portion of my life benefits?

No. The Group Policy is written to pay the percentage you list for each named beneficiary regardless of whether you have a spouse. Naming your beneficiary is strictly your personal decision. The Standard cannot provide you with legal advice on this matter.

If I live in a community property state and do not name my spouse as beneficiary for a portion of the benefits, can my spouse sue the named beneficiary to get a portion of the benefits?

If state law governs the Group Policy and you live in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), your spouse may have a legal claim for a portion of the benefits under community property law. However, that would be an issue involving your spouse and the named beneficiary, to be decided by a court of law. The Standard will not decide whether a spouse who is not named as a beneficiary has a valid community property claim to the benefits. The Standard will pay your life benefits to your named beneficiary, unless a court order requires payment to someone else.

Can I name my ex-spouse as beneficiary?

If state law governs the Group Policy, in many states divorce (or annulment) automatically revokes a designation of your ex-spouse as a beneficiary that you made before the divorce. If you divorce and wish to keep your ex-spouse as your beneficiary, you must complete a new beneficiary designation after your divorce is final. In general, if state law revokes the designation of your ex-spouse, then The Standard cannot pay the benefits to your ex-spouse unless you have named your ex-spouse as beneficiary after the divorce, you have remarried your ex-spouse, or a court order requires payment to your ex-spouse.

Who will get my life benefits if my primary beneficiary designation is revoked by law?

If you named a contingent beneficiary, this beneficiary will receive your benefits. If you did not name a contingent beneficiary The Standard typically will pay the benefits according to the policy order as described above.

Can I designate my minor child or children to be my beneficiary?

Yes. However, when the life benefits are payable to your child who is under the age of majority (usually age 18 or 21, depending on state law), The Standard may place the funds in an interest-bearing account maintained by The Standard until your child reaches the age of majority. For a child under the age of majority, a court-appointed guardian of the child's estate may contact The Standard to collect the benefits.

If you wish to have your minor children receive your life benefits, you should consult with your legal advisor to determine the best way to accomplish this under the laws of your state of residence.

What if I have children aged 18, 15 and 10? Will they all get paid the benefits if I die?

You may name your three children to receive a designated percentage of the benefits. In this case, the percentage of the benefits designated for your 18-year-old child will be payable to that child upon your death if 18 is the age of majority in your state of residence. The percentage of the benefits designated to the children under age 18 may be maintained by The Standard in an interest-bearing account and paid when each child reaches the age of majority or when a court-appointed guardian of the child's estate contacts The Standard to collect the benefits.

If my will states that a relative (or other trusted individual) will be responsible for my minor child, who do I name as a beneficiary?

A will generally has no effect on who will receive life insurance benefits. The benefits can be paid to the individual named in your will only if that person is also named as your beneficiary or if he/she obtains legal guardianship of your child's estate.

Can I designate a relative (or other trusted individual) to receive life insurance benefits in trust for my minor children?

Yes, but the individual will need to obtain legal guardianship of your child's estate before The Standard can make payment.

Who can I name on the beneficiary form if I have a will?

Even if you have a will, you can name any person you wish as your life insurance beneficiary. If you wish to have the benefits paid to your estate, you may name your estate as your beneficiary. After your death, a court-appointed personal representative named in your probated will files the claim for benefits.

Can the attorney in fact I name in my Power of Attorney complete my beneficiary designation form, and can he/she name him/herself as beneficiary?

A Power of Attorney must grant your attorney in fact specific authority, by the terms of the Power of Attorney document or applicable law, to make or change a beneficiary designation. Broad general grants of authority in a Power of Attorney often are not sufficient to make such a designation. If you have questions, consult your legal advisor.

Can I name a trust* as beneficiary?

Yes. However, if you name a trust as beneficiary, a valid trust must exist at the time of your death. If the trust was never established, is not in existence, or has been revoked by the time you die, then The Standard cannot honor that beneficiary designation and will be required to pay the benefits to a contingent beneficiary or under the policy order. You should consult your legal advisor as to how to establish a valid trust and determine if naming a trust as beneficiary is appropriate for your financial and estate-planning needs.

If I have Dependents Life coverage for my spouse or children, am I the beneficiary?

Typically, you as the insured member are automatically the beneficiary.

How often can I change my beneficiary?

You can change your beneficiary as often as you wish. Beneficiary forms typically are maintained by your benefits administration office. If so, you should request, complete and return beneficiary forms to that office.

* Trust definition: Generally, a trust is a written document under which money or other assets are transferred from one person (the grantor) to another person or institution such as a bank (the trustee), to be managed and used for the benefit of a third person (the beneficiary). There are two basic types of trusts: living (or inter vivos) trusts and testamentary trusts. Living trusts are created during the lifetime of the grantor. Life insurance proceeds which are distributed to a living trust will avoid probate. Testamentary trusts are drafted as part of a will and take effect after the death of the grantor. Proceeds distributed through a testamentary trust pass through the probate process after the grantor's death because the trust is included in the will.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

www.standard.com

Assigning Beneficiaries FAQ
760741
SI **18328** (10/24)

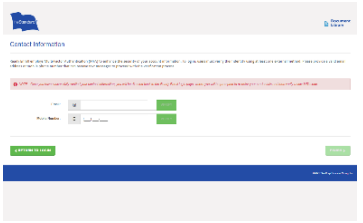
Palm Beach County Board of County Commissioners
Ready Enroll Employee Guide

Logging In/Forgot Login Information

- Open the online portal site at https://standard.benselect.com/palmbeach
- Your username is your legal first name + the last 4 of your SSN (*all lowercase*).
- When you first log in, your personal identification number (PIN) will be the last four digits of your SSN followed by the last two digits of your birth year.
- *If you have previously logged in and forgot your password, click "Forgot your PIN?"*

Two-factor Authentication (MFA)

- After entering your credentials, you will be prompted to request the two-factor authentication code. The code can be sent to either an e-mail or mobile number by clicking on Request Code and entering it back into the prompt. (This will depend on whether your contact information has been previously provided)
- If your contact information has not been provided.
    - You will need authenticate your contact information prior to moving forward. This will occur after you have entered your initial credentials and will be followed by a "Contact Information" verification page.
    - Enter your contact information and click VERIFY. An authentication code will be sent to your e-mail or mobile number for verification.
    - Once you have successfully verified your contact information, you will be directed back to the Ready Enroll login page, where you will be prompted to re-enter your credentials and then verify a new authentication code.



Change PIN

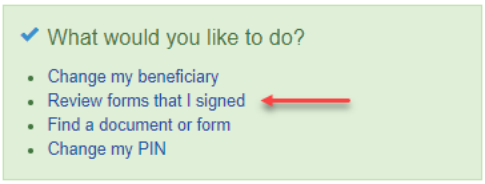
- The first time you log in, you will be prompted to change your PIN. Your personalized pin must be a minimum of eight characters and include at least three of the following: UPPER case letter, lower case letter, number, a special character.
- Answer the security questions and enter in your email address. In most situations, your email address is your work email, alternatively it would be the email you have provided to your employer.
- Once you have entered your information, click SAVE NEW PIN
- *If you have previously logged in and forgot your password, click "Forgot your PIN?"*

Home Screen

- Once you have logged in, click NEXT. This will guide you through the entire enrollment process.
- Utilize the home screen navigation options to get to the specific thing you would like to do (*ie. change beneficiary).*
- You will be able to logout and re-enter the portal any time to continue the process or modify your enrollments.
- Any changes or elections you saved will be available each time you logout or time out due to in-activity.

Beneficiaries

- Click + to add a new beneficiary or click pencil icon to change an existing beneficiary or X to delete a beneficiary.
- If the beneficiary you would like to designate is already listed, click the check box.
- You may designate more than one beneficiary and allocate different percentages between them.
- To find your current beneficiary designations, from the home page, select "Review Forms that I signed"



Navigation

- If at any point you would like to go back to make a change, you can click the 'Next' button or click on 'My Designations' at the top to navigate back to your beneficiary designation.
- To make a change to your beneficiary, click the UNLOCK button and continue through the designation process.

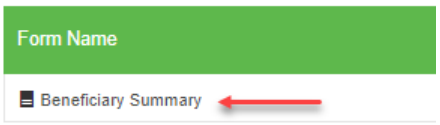
Submit Designation

- After verifying your beneficiary designations, you will be brought to the Submit Your Designation screen. Your designation is not complete until you have clicked the I AGREE button on the bottom of this screen.

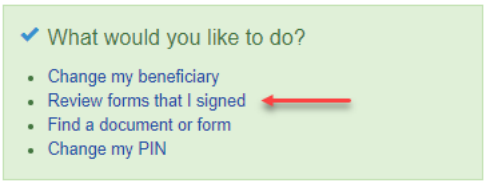
Beneficiary Summary

You can access your Summary in two ways.

- Upon completion of your designation
  - From the Sign/Submit Complete screen, you may obtain copies of your designation summary. Scroll to the bottom of the page and click "Beneficiary Summary"



  - From the home page screen, you may select "Review Forms that I signed"



  - Please note: If you do not advance through the Submit Designation screens, you will not have a Beneficiary Summary.

TRAVEL ASSISTANCE AND LIFE SERVICES TOOLKIT[1]

Because Today, More Than Ever, Employees Need Support

With The Standard's Life insurance, employees also get services and tools they can use right now.

Life Services Toolkit

Help employees can use now — and support for beneficiaries after a death

Participant Services

- Estate planning assistance
- Funeral arrangements
- Identify theft prevention
- Financial planning
- Health and wellness

Beneficiary Services

- Grief support
- Legal services
- Financial counseling
- Support services
- Online resources

Travel Assistance

Connects employees to resources 24/7 before and during a trip

Available when employees travel more than 100 miles from home for up to 180 days for business or pleasure

Also covers employee's spouse and kids through age 25[2]

Easy access via the Assist America Mobile App

Basic and emergency services include:

- Help replacing lost or stolen items
- Assistance with medical needs
- Accessing interpretation/translation services
- Emergency transportation services — must be arranged by Assist America, Inc.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | standard.com

1 Life Services Toolkit is provided through an arrangement with Health Advocate™ and is not affiliated with The Standard. Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. The Life Services Toolkit and Travel Assistance are not insurance products.

2 Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

DISABILITY INSURANCE

DISABILITY INSURANCE

The Standard

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 The Standard. Evidence of Insurability may be required. Approval of coverage may be contingent on medical underwriting as determined by the contracted carrier.

LATE ENROLLMENT - Approval may be contingent on medical underwriting

The Standard 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

Review the disability coverage certificates for more information

DISABILITY INSURANCE

The Standard

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 – The Standard Group Insurance

EE Only - Weekly benefit is 67% of gross/max $1200/week. 100% employee paid $11.83 - Bi-weekly Rate

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

- Employees who did not enroll in this benefit when 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
  - **Cost: $11.83 bi-weekly; $ 23.66 monthly**
- Active Work Requirement: If you are incapable of Active Work because of Physical Disease, Injury, Pregnancy or Mental Disorder on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible member

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

DISABILITY INSURANCE

The Standard

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 – The Standard Group Insurance

- **Free Basic 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.** Cost is based on salary. Use formula to calculate rate:

- Employee with HMO/CHOICE: Annual salary ÷ 12 months x .0046 - $4.30 = monthly ÷ 2 = biweekly rate

- Employee without HMO/CHOICE: Annual salary ÷ 12 months x .0059 = monthly ÷ 2 = biweekly rate

Example: ***Employee with HMO/CHOICE plan @ $50,000/year will pay $7.43 bi-weekly◆Employee with POS/Opt-Out @ $50,000 will pay $12.29 bi-weekly***

Key Features:

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

DISABILITY INSURANCE

- Visit **www.Standard.com/disability/needs** to access the Disability Insurance Needs Calculator (Consumer Toolkit section) and other information about disability insurance.

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

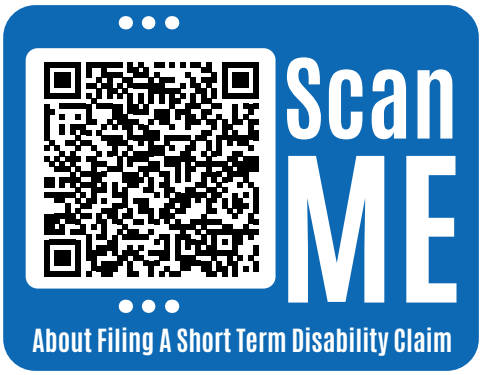
- This benefit is intended to protect employees who are disabled for over 90 days and unable to return to work because of a covered disability
- The benefit offers HMO and CHOICE health plan participants a maximum monthly benefit of up to $1,000 ($100 minimum monthly benefit)

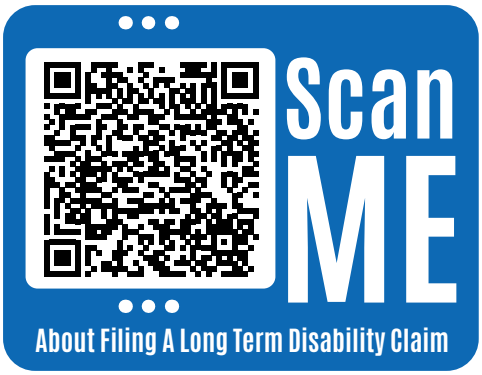
This benefit is offered at no cost to the employee and is available only to employees who participate in the UNITED HEALTHCARE **HMO health plan or CHOICE health plan** through BCC

- 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)





FLEXIBLE BENEFITS PLAN

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 - $3,300 max annually or $10.00 - $126.92 bi-weekly
- Dependent Care FSA contributions: $260 min - $5,000 max annually or $10.00 min – $192.31 biweekly

County of Palm Beach

FSA Rules to Remember

PLAN YEAR

January 1, 2025 - December 31, 2025

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, 2026 to incur expenses during the plan year.

RUN-OUT PERIOD

You have until April 30, 2026 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: $3,300

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: $5,000

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

FLEXIBLE SPENDING ACCOUNT

P&A BENEFITS CARD

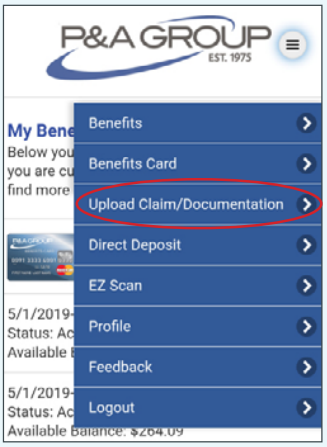
Your employer offers a Benefits MasterCard for employees who participate in the plan. The Benefits MasterCard works like a debit card. When you incur an eligible expense, swipe your card at the point-of-service and the expense will automatically be deducted from your FSA balance. If you are unable to 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.

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).

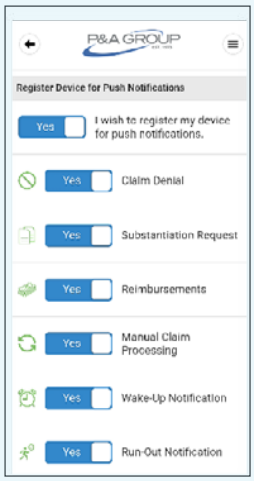
MOBILE APP

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

Download on the App Store | GET IT ON Google Play

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

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	EMERGENCY ROOM OR URGENT CARE VISITS
DOCTOR APPOINTMENTS, SURGERIES, LAB TESTS & MORE	CANCER & ACCIDENTAL INJURIES

Scan ME

https://www.mybensite.com/pbcgov/Plan

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

EMPLOYEE ASSISTANCE PROGRAM

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 maysuggest to an employee that he/she seek help when there is a workperformance problem or when specific on-the-job incidents indicatethat 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 pay period following the coverage end date for coverage termination and employment separation. Accordingly, deductions usually will be applied to any checks as long as the employee has coverage for all or some of the pay period for which the paycheck is processed.

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

Retiree Insurance – Continuation of Coverage for Retirees
Florida Law (112.0801) requires that Palm Beach County makes available to retirees the same medical and dental plan benefits 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

NOTICES

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].

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.

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).

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	**EFFECTIVE DATE**
April 29, 2025	**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	• 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
• Domestic partner of the same or opposite sex	• 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

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).

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, ease management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

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

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

Uses and disclosures that require your consent

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

Uses and disclosures that require your written authorization

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

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

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

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

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

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

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

reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5. The Plan may disclose your PHI when required for judicial or administrative proceedings, For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. When required for law enforcement purposes (for example, to report certain types of wounds).
7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement arid 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 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 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;
- 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: Reginald Duren, Assistant County Administrator, 301 N Olive Ave, West Palm Beach, Florida 33401,

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

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

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

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

Conclusion

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

Questions

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

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **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, 2021, or to view states that have recently added a premium assistance program since July 31, 2021, 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

IMPORTANT GENERAL NOTICE OF COBRA CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS

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

INTRODUCTION

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

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

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

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

COBRA COVERAGE

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

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

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

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

QUALIFYING EVENTS

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

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

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

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

NOTICE OF QUALIFYING EVENTS

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

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

ELECTING COBRA COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTICE PROCEDURES FOR QUALIFIED BENEFICIARIES
Any required notice the qualified beneficiary is required to furnish (as described above) must follow these notices procedures. Notices must be sent to CONEXIS in writing (by mail or electronic transmittal [e.g., facsimile, e-mail]) to:
CONEXIS
P.O. Box 223684, Dallas, TX 75222-3684
memberservices@conexis.com

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

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

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

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 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:

[ ]

[x] Some employees. Eligible employees are:

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

- With respect to dependents:

[x] 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** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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

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

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

NOTICE REGARDING WELLNESS PROGRAM

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

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

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

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

Protections from Disclosure of Medical Information

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

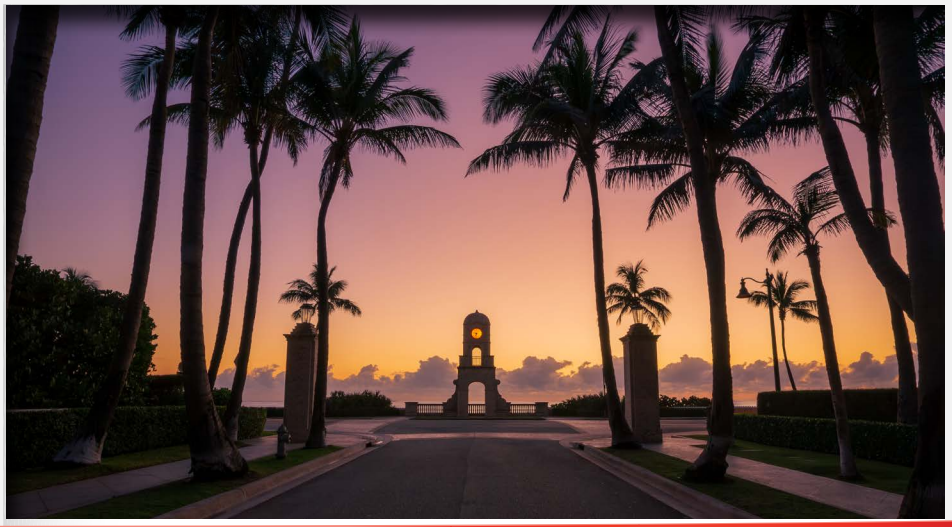
use aggregate information it collects to design a program based on identified health risks in the workplace, the Employee Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation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

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

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

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

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



Thank you!

Contract Administrator
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