RESOLUTION NO. 15 - 2318

A RESOLUTION OF THE TOWN COMMISSION FOR THE TOWN OF SURFSIDE, FLORIDA, APPROVING THE GROUP HEALTH AND VISION WITH UNITEDHEALTHCARE, DENTAL COVERAGE WITH GUARDIAN AND TERM LIFE INSURANCE, ACCIDENTAL DEATH, SHORT TERM DISABILILTY, AND LONG TERM DISABILITY WITH MUTUAL OF OMAHA; PROVIDING FOR APPROVAL AND AUTHORIZATION; PROVIDING FOR AN EFFECTIVE DATE.

WHEREAS, the Adams Benefit, Inc. is the Town of Surfside ("Town") agent of record and has analyzed the best proposals from competitive health care and other benefit providers for the Town employees every year; and

WHEREAS, the dental coverage will be transferred from UnitedHealthcare to Guardian, who provides a large network and lower premiums; and

WHEREAS, the Town intends to continue to engage and renew with UnitedHealthcare and Mutual of Omaha to arrange for the delivery of health and other benefits for Fiscal Year 2015/2016, for qualified Town employees; and

WHEREAS, the Town Commission believes that it is in the best interest of the Town to accept the proposals of these companies (See Attachment "A").

NOW THEREFORE, BE IT RESOLVED BY THE TOWN COMMISSION OF THE TOWN OF SURFSIDE, FLORIDA, AS FOLLOWS:

Section 1. Recitals. The above and foregoing recitals are true and correct and are incorporated herein by reference.

Section 2. Approval and Authorization. The Town Commission hereby approves and authorizes the Town Manager and/or designee to enter into an agreement with UnitedHealthcare, Guardian and Mutual of Omaha for group health and other benefits, based on the terms of the proposals attached hereto as Attachment "A."

Section 3. Effective Date. This Resolution shall become effective immediately upon its adoption.

PASSED and **ADOPTED** on this 8th day of September 2015.

Motion by Vice Mayor Tourgeman,

Second by Commissioner Cohen.

FINAL VOTE ON ADOPTION

Commissioner Barry R. Cohen	Yes
Commissioner Michael Karukin	Yes
Commissioner Marta Olchyk	Yes
Vice Mayor Eli Tourgeman	Yes
Mayor Daniel Dietch	Yes

Daniel Dietch, Mayor

ATTEST:

Sandra Novoa, Town Clerk

APPROVED AS TO FORM AND LEGAL SUFFICIENCY:

Linda Miller, Town Attorney

UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

Florida - Choice
Consumer - 20/1000/100% Plan 0H9

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

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

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits
Annual Deductible	
Individual Deductible	$1,000 per year
Family Deductible	$2,000 per year

> Copayments do not accumulate towards the Deductible.

> All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

Out-of-Pocket Maximum	
Individual Out-of-Pocket Maximum	$3,000 per year
Family Out-of-Pocket Maximum	$6,000 per year

> All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.

> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

FLCA040H914

Item#	Rev. Date	
213-6282	0913_rev03	Base/Value/Sep/Emb/12828/2011/HMO

UnitedHealthcare of Florida, Inc.

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Contract or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits
Physician's Office Services - Sickness and Injury	
Primary Physician Office Visit	100% after you pay a $20 Copayment per visit.
Specialist Physician Office Visit	100% after you pay a $40 Copayment per visit.

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services	
Covered Health Services include but are not limited to:	
Primary Physician Office Visit	100%, Copayments and Deductibles do not apply.
Specialist Physician Office Visit	100%, Copayments and Deductibles do not apply.
Lab, X-Ray or other preventive tests	100%, Copayments and Deductibles do not apply.

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Urgent Care Center Services	
	100% after you pay a $100 Copayment per visit.

> In addition to the Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Emergency Health Services - Outpatient	
	100% after you pay a $350 Copayment per visit. *Notification is required if confined in a non-Network Hospital.*
Hospital - Inpatient Stay	
	100% after Deductible has been met.

Types of Coverage	Network Benefits
Ambulance Service - Emergency and Non-Emergency	
Ground Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	100% after Deductible has been met.
Air Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	100% after Deductible has been met.
	Prior Authorization is required for non-Emergency Ambulance.
Congenital Heart Disease (CHD) Surgeries	
	100% after Deductible has been met.
Dental Services - Accident Only	
	100% after Deductible has been met. *Prior Authorization is required.*
Diabetes Services	
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider. However diabetes self-management items are not subject to any limits.
Durable Medical Equipment	
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	100% after Deductible has been met.
Habilitative Services	
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.
Hearing Aids	
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/ replacement) per hearing impaired ear every three years.	100% after Deductible has been met.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits
Home Health Care	
Benefits are limited as follows: 60 visits per year	100% after Deductible has been met.
Hospice Care	
	100% after Deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient	
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	
Lab Testing - Outpatient	100% Deductible does not apply.
X-Ray and Other Diagnostic Testing - Outpatient	100% Deductible does not apply.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	100% after Deductible has been met.
Ostomy Supplies	
Benefits are limited as follows: $2,500 per year	100% after Deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	100% after Deductible has been met.
Physician Fees for Surgical and Medical Services	
	100% after Deductible has been met.
Pregnancy - Maternity Services	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.
Prosthetic Devices	
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	100% after Deductible has been met.
Reconstructive Procedures	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.

Types of Coverage	Network Benefits
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	
Benefits are limited as follows: 20 visits of Manipulative Treatments 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy	100% after you pay a $20 Copayment per visit.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	100% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Benefits are limited as follows: 60 days per year	100% after Deductible has been met.
Surgery - Outpatient	
	100% after Deductible has been met.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	100% after Deductible has been met.
Transplantation Services	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For Network Benefits, services must be received at a Designated Facility. *Prior Authorization is required.*

Types of Coverage	Network Benefits
Autism Spectrum Disorder	
Note: The visit limits specified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder.	100% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*
Bones or Joints of the Jaw and Facial Region	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Prior Authorization is required as described in your Schedule of Benefits.*
Cleft Lip/Cleft Palate Treatment	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Prior Authorization is required as described in your Schedule of Benefits.*
Clinical Trials	
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Prior Authorization is required.*
Dental Services - Anesthesia and Hospitalization	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Prior Authorization is required as described in your Schedule of Benefits.*
Enteral Formulas	
	100% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*
Mental Health Services	
	Inpatient: 100% after Deductible has been met. Outpatient: 100% after you pay a $40 Copayment per visit.
Neurobiological Disorders – Autism Spectrum Disorder Services	
	Inpatient: 100% after Deductible has been met. Outpatient: 100% after you pay a $40 Copayment per visit.

Types of Coverage	Network Benefits
Osteoporosis Treatment	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Prior Authorization is required as described in your Schedule of Benefits.*
Substance Use Disorder Services	
	Inpatient: 100% after Deductible has been met. Outpatient: 100% after you pay a $40 Copayment per visit.

EXCLUSIONS

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

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Contract, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

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

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness, that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Neurobiological Disorders – Autism Spectrum Disorders

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder, except as described under Autism Spectrum Disorder in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Benefits described under Enteral Formulas in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorders. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. This exclusion does not apply to Benefits described under Bones or Joints of the Jaw or Facial Region in Section 1 of the COC. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

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

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is paid under arrangements required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage paid by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Contract.) Health services for transplants involving permanent mechanical or animal organs. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Contract. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Contract when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Contract ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Contract ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Contract. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

Florida - Choice Plus
HSA - 2000/90% Plan 5Q3

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

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

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible - Combined Medical and Pharmacy		
Single Coverage Deductible	$2,000 per year	$5,000 per year
Family Coverage Deductible	$4,000 per year	$10,000 per year

> No one in the family is eligible for benefits until the family coverage deductible is met.

Out-of-Pocket Maximum - Combined Medical and Pharmacy		
Single Coverage Out-of-Pocket Maximum	$4,000 per year	$10,000 per year
Family Coverage Out-of-Pocket Maximum	$8,000 per year	$20,000 per year

> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

> If more than one person in a family is covered under the Policy, the single Out-of-Pocket Maximum stated above does not apply.

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Item#	Rev. Date	
213-6946	1213	Base/Value HSA/Comb/NonEmb/14515/2011/INS

UnitedHealthcare Insurance Company

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid.

> When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	90% after Deductible has been met.	50% after Deductible has been met.
Specialist Physician Office Visit	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for Genetic Testing - BRCA.*
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100%, Copayments and Deductibles do not apply.	Non-Network Benefits are not available, except for "Child Health Supervision Services," one annual female physical, including a pap smear and a mammogram.
Specialist Physician Office Visit	100%, Copayments and Deductibles do not apply.	
Lab, X-Ray or other preventive tests	100%, Copayments and Deductibles do not apply.	

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Urgent Care Center Services		
	90% after Deductible has been met.	50% after Deductible has been met.
Emergency Health Services - Outpatient		
	90% after Deductible has been met.	90% after Network Deductible has been met. *Notification is required if confined in a non-Network Hospital.*

MOST COMMONLY USED BENEFITS

YOUR BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Hospital - Inpatient Stay		
	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	90% after Deductible has been met.	90% after Network Deductible has been met.
Air Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	90% after Deductible has been met.	90% after Network Deductible has been met.
	Prior Authorization is required for non-Emergency Ambulance.	*Prior Authorization is required for non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required.*
Dental Services - Accident Only		
	90% after Deductible has been met. *Prior Authorization is required.*	90% after Network Deductible has been met. *Prior Authorization is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider. However diabetes self-management items are not subject to any limits.	*Prior Authorization is required for Durable Medical Equipment in excess of $1,000.*
Durable Medical Equipment		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for Durable Medical Equipment in excess of $1,000.*
Habilitative Services		
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.	
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/ replacement) per hearing impaired ear every three years.	90% after Deductible has been met.	50% after Deductible has been met.

Types of Coverage	Network Benefits	Non-Network Benefits
Home Health Care		
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required.*
Hospice Care		
	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for Inpatient Stay.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	90% after Deductible has been met.	50% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for sleep studies.*
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required.*
Ostomy Supplies		
Benefits are limited as follows: $2,500 per year	90% after Deductible has been met.	50% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	90% after Deductible has been met.	50% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	90% after Deductible has been met.	50% after Deductible has been met.
Pregnancy - Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for Prosthetic Devices in excess of $1,000.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of Manipulative Treatments 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy	90% after Deductible has been met.	50% after Deductible has been met.
		Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	90% after Deductible has been met.	50% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	90% after Deductible has been met.	50% after Deductible has been met.
		Prior Authorization is required.
Surgery - Outpatient		
	90% after Deductible has been met.	50% after Deductible has been met.
		Prior Authorization is required for certain services.

Types of Coverage	Network Benefits	Non-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	90% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for certain services.*
Transplantation Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For Network Benefits, services must be received at a Designated Facility. *Prior Authorization is required.*	*Prior Authorization is required.*

Types of Coverage	Network Benefits	Non-Network Benefits
Autism Spectrum Disorder		
Note: The visit limits specified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Bones or Joints of the Jaw and Facial Region		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Cleft Lip/Cleft Palate Treatment		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization is required.	*Prior Authorization is required.*
Dental Services - Anesthesia and Hospitalization		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Enteral Formulas		
	90% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Mental Health Services		
	Inpatient: 90% after Deductible has been met.	Inpatient: 50% after Deductible has been met.
	Outpatient: 90% after Deductible has been met.	Outpatient: 50% after Deductible has been met.
		Prior Authorization is required for certain services.

Types of Coverage	Network Benefits	Non-Network Benefits
Neurobiological Disorders – Autism Spectrum Disorder Services		
	Inpatient: 90% after Deductible has been met. Outpatient: 90% after Deductible has been met.	Inpatient: 50% after Deductible has been met. Outpatient: 50% after Deductible has been met. *Prior Authorization is required for certain services.*
Osteoporosis Treatment		
	90% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*	50% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*
Substance Use Disorder Services		
	Inpatient: 90% after Deductible has been met. Outpatient: 90% after Deductible has been met.	Inpatient: 50% after Deductible has been met. Outpatient: 50% after Deductible has been met. *Prior Authorization is required for certain services.*

EXCLUSIONS

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

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

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

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness, that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Neurobiological Disorders – Autism Spectrum Disorders

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder, except as described under Autism Spectrum Disorder in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Benefits described under Enteral Formulas in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorders. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. This exclusion does not apply to Benefits described under Bones or Joints of the Jaw or Facial Region in Section 1 of the COC. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

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

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is paid under arrangements required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage paid by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

UnitedHealthcare®

Vision Benefit Summary
www.myuhcvision.com
Customer Service: (800) 638-3120
Provider Locator: (800) 839-3242

Plan V0008

	NETWORK	NON-NETWORK
Comprehensive Vision Exam	$10 Copay	Up to $40
Materials - Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$25 Copay[1]	See below
Frequencies - Based on last date of service	Exam Once every 12 months Lenses Once every 12 months Frames Once every 24 months	

COVERED SERVICES	NETWORK	NON-NETWORK
Pair of Lenses (for Eyewear)		
• Standard single vision lenses • Standard lined bifocal lenses • Standard lined trifocal lenses • Standard lenticular lenses Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.	Covered in full after applicable copay[1] Includes standard scratch-resistant coating	Up to $40 Up to $60 Up to $80 Up to $80
Frames		
You will receive a $50 wholesale frame allowance (approximate retail value of $120-$150) at our private practice providers; or a $130 retail frame allowance at our retail chain providers. For frames which exceed the allowance, you may receive an additional 30% discount, available only at participating providers.	Up to $50 wholesale/$130 retail frame allowance (after applicable copay [1])	Up to $45
Contact Lenses[2]		
• Covered contact lens selection It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today.[3] A complete list can be found by visiting our website www.myuhcvision.com.	Up to 4 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay [1])	Up to $105
• Non-selection contacts You receive an allowance which is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $105 (material copay is waived)	Up to $105
• Necessary contact lenses[4]	Covered in full after applicable copay[1]	Up to $210

[1] The material copayment will apply once if frames and lenses, or contact lenses in lieu of eyewear, are purchased at the same time at a network provider.

[2] Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.

[3] Coverage for Covered Contact Lens Selection does not apply at Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

[4] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or eyeglass frames; with certain conditions of anisometropia, keratoconus, irregular corneals/astigmatism, aphakia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare concerning the reimbursement that UnitedHealthcare will make before you purchase such contacts.

UNITED *of* OMAHA LIFE INSURANCE COMPANY

TERM LIFE AND AD&D INSURANCE BENEFITS SUMMARY

For Employees of Town of Surfside

ELIGIBILITY - ALL ELIGIBLE ACTIVE EMPLOYEES	
Eligibility Requirement	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
Minimum Work Hours	You must be working a minimum of 32 hours per week to be eligible for coverage.
Coverage Payment	Your employer pays 100% of the premium for this coverage.
GUARANTEE ISSUE AMOUNT(S)	
For You	$175,000
Note: Subject to any reductions shown below, guarantee issue means the amount of insurance applied for which does not require evidence of insurability. Guarantee Issue is available to New Hires only. For New Hires, coverage amounts over the Guarantee Issue Amount will require a health application/evidence of insurability. For Late Entrants, all coverage amounts will require a health application/evidence of insurability.	
BENEFITS	
Life Insurance Benefit Amount	For You: An amount equal to 1times your annual salary, up to $175,000* ** In the event of death, the benefit paid will equal the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.*
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of life insurance benefit.
FEATURES	
Living Care/Accelerated Death Benefit	50% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $100,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Child Education - Seat Belt - Airbag - Common Carrier - Paralysis
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.	

AGE REDUCTIONS AND EXCLUSIONS

Your life insurance benefits and guarantee issue amounts are subject to age reductions. At age 65, amounts reduce to 65%. At age 70+, amounts reduce to 50%. Coverage terminates at retirement.

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

Please contact your employer if you have questions prior to enrolling.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Term life insurance and accidental death & dismemberment insurance are underwritten by United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175. United of Omaha Life Insurance Company is licensed in every state except New York. Term Life Policy Form Number 7000GM-C-EZ-2001. AD&D Policy Form Number 7000M-M-EZ 2001.

SHORT-TERM DISABILITY INSURANCE BENEFITS SUMMARY

For Employees of Town of Surfside

ELIGIBILITY - ALL ELIGIBLE Active EMPLOYEES	
Eligibility Requirement	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
Minimum Work Hours	You must be working a minimum of 32 hours per week to be eligible for coverage.
Coverage Payment	Your employer pays 100% of the premium for this coverage.
BENEFITS	
Benefits Begin (Elimination Period)	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: ▪ On the 15th day of your disabling injury. ▪ On the 15th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 66% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount.
Maximum Benefit Period	Short-term disability benefits are available for up to 24 weeks .
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	None
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings is the gross weekly income you receive from your employer for the week immediately prior to the onset of disability, which is used to determine your benefit in the event of a claim. Earnings may include commissions, bonuses, overtime, shift differential pay or other extra compensation.
FEATURES	
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a weekly benefit increase of 5%.
Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.	
EXCLUSIONS & LIMITATIONS	
Information about the exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.	

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Short-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.

UNITED *of* OMAHA LIFE INSURANCE COMPANY

LONG-TERM DISABILITY INSURANCE BENEFITS SUMMARY

For Employees of Town of Surfside

ELIGIBILITY - ALL ELIGIBLE Active EMPLOYEES	
Eligibility Requirement	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
Minimum Work Hours	You must be working a minimum of 32 hours per week to be eligible for coverage.
Coverage Payment	Your employer pays 100% of the premium for this coverage.
BENEFITS	
Benefits Begin (Elimination Period)	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin 180 days after the onset of your disabling injury or illness.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources.
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65 or your Social Security Normal Retirement Age. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Maximum Monthly Benefit	$7,000
Minimum Monthly Benefit	$50
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are: ▪ Prevented from performing at least one of the material duties of your regular occupation during the first 24 months of disability and after 24 months are unable to perform all of the material duties of any gainful occupation; and ▪ During the first 24 months of disability are unable to generate current earnings which exceed 99% of your monthly earnings from your regular occupation, and after 24 months if partially disabled, are unable to generate current earnings which exceed 85% of your monthly earnings from any gainful occupation. You can be totally or partially disabled during the elimination period.
Definition of Monthly Earnings	Monthly earnings is the gross monthly income you receive from your employer for the month immediately prior to the onset of disability, which is used to determine your benefit in the event of a claim. Earnings may include commissions, bonuses, overtime, shift differential pay or other extra compensation.
FEATURES	
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a monthly benefit increase of 5%.
Survivor Benefit	If you pass away while receiving long-term disability benefits, your benefits will be provided to your beneficiaries for a period of time after your death.
Waiver of Premium	The premium for your long-term disability coverage is waived while you are receiving benefits.
Employee Assistance Program	The EAP program provides you and your loved ones access to trained professionals and resources for assistance with personal and workplace issues.
Alcohol & Drug Abuse	For disabilities related to drug and alcohol abuse, benefits are available for up to 24 months.
Mental Disorders	For disabilities related to mental disorders, benefits are available for up to 24 months.
Specific Conditions	For disabilities related to specific conditions, benefits are available for up to 24 months.

FEATURES (CONTINUED)	
Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.	
EXCLUSIONS & LIMITATIONS	
Pre-existing Conditions Exclusion	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 3 months prior to coverage are excluded.
Other Exclusions	Information about other exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Long-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.

GUARDIAN®

Dental Benefit Summary

Group Number: 00516368

About Your Benefits:

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400[1]? Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country, who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same community, you will benefit from lower out-of-pocket costs, quality care from screened and reviewed dentist, no claim forms to file, and excellent customer service. Enroll today and smile next time you see your dentist!

[1]http://health.costhelper.com/dental-crown.html.

Option 1: With your **Pre-Paid** plan, you enjoy negotiated discounts from our network dentists. You pay a fixed copay for each covered service. Out-of-network visits are not covered.

Option 2: With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	**Option 1: Pre-Paid**	**Option 2: PPO**	
Your Network is	Managed DentalGuard	DentalGuard Preferred	
Calendar year deductible		*In-Network*	*Out-of-Network*
Individual	No deductible	$50	$50
Family limit		3 per family	
Waived for		Preventive	Preventive
Charges covered for you (co-insurance)	*Network only*	*In-Network*	*Out-of-Network*
Preventive Care	You pay a copay for each	100%	100%
Basic Care	covered procedure. See	90%	80%
Major Care	"Plan Details", for	60%	50%
Orthodontia	more information.	50%	50%
Annual Maximum Benefit	Unlimited	$2000	$2000
Maximum Rollover	Maximum Rollover is not	Yes	
Rollover Threshold	applicable for this plan type.	$800	
Rollover Amount		$400	
Rollover In-network Amount		$600	
Rollover Account Limit		$1500	
Lifetime Orthodontia Maximum	Not Applicable	$1500	
Office visit copay	$0	None	
Dependent Age Limits	26 *	26 *	

***Family coverage** for spouse and children if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.

A Sample of Services Covered by Your Plan:

		Option 1: Pre-Paid *You Pay*	Option 2: PPO *Plan pays (on average)*	
		Network only	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	$0	100%	100%
	Frequency:	2 times in 12 months^	2 in 12 Months	
	Fluoride Treatments	$0	100%	100%
	Limits:	No Age Limits	Under Age 19	
	Oral Exams	$0	100%	100%
	Sealants (per tooth)	$0	100%	100%
	X-rays	$0	100%	100%
Basic Care	Anesthesia*	Restrictions Apply	90%	80%
	Fillings‡	$0	90%	80%
	Perio Surgery	$200-380	90%	80%
	Periodontal Maintenance	$0	90%	80%
	Frequency:	2 times in 12 months^ (Standard)	Once Every 6 Months (Standard)	
	Root Canal	$120-270	90%	80%
	Scaling & Root Planing (per quadrant)	$0	90%	80%
	Simple Extractions	$0	90%	80%
	Surgical Extractions	$30-200	90%	80%
Major Care	Bridges and Dentures	$381-575	60%	50%
	Inlays, Onlays, Veneers**	$250-370	60%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	$0-160	60%	50%
	Single Crowns	$375	60%	50%
Orthodontia	Orthodontia	$1,500-2,800	50%	50%
	Limits:	Adults & Child(ren)	Child(ren)	
Cosmetic Care	Bleaching	$165	Not Covered	Not Covered

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings. (^Additional cleanings are available for an additional co-pay).

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00516368

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan and dental network, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

- Imlmportant information about Guardian's Managed DentalGuard Pre-Paid (Florida, New York) Plan, Guardian's Managed DentalGuard (Colorado) Plan , Managed DentalGuard Inc.'s (Ohio) Plan, Managed Dental Care's DHMO (California) Plan, Managed DentalGuard, Inc.'s Managed DentalGuard (New Jersey) Plan, Managed DentalGuard, Inc.'s Managed DentalGuard DHMO (Texas) Plan and Managed DentalGuard -LIBERTY Dental Plan of Nevada, Inc. (Nevada): This plan provides pre-paid dental benefits through a network of participating general dentists and specialty care dentists. All covered services must be provided by the member's Primary Care Dentist. Specialty care services are covered only when referred by the member's Primary Care Dentist and approved in advance by Managed DentalGuard. Only those services listed in the plan are covered. Certain services are subject to annual or other periodic limitations. Where orthodontic benefits are specifically included, the plan provides for one course of comprehensive treatment per lifetime, per member. Unless specifically included, the Managed DentalGuard plan does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under the Managed DentalGuard plan. The services, exclusions and limitations listed here do not constitute a contract and are a summary only. The Managed DentalGuard plan documents are the final arbiter of coverage. GP-1-MDG1, et al. or GP-1-MDG-FL-1-08, et al. (Florida), GP-1-MDG-NY1, et al. or GP-1-MDG-NY-1-08, et al. (New York), GP-1-MDG-CO-1, et al. (Colorado), GP-1MDC1, et al. or GP-1-MDC-CA-1-08, et al. (California), GP-1-MDG-1-NJ, et al. or GP-1-MDG-NJ-1-08, et al. (New Jersey), GP-1-MDG-TX1, et al. or GP-1-MDG-TX-1-08, et al. (Texas), GP-1-MDG-OH-1, et al. (Ohio), NV110717, et al (Nevada).
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3 – DG2000