Your wellness is our focus.

2011 Benefits Guide

For assistance in English, please call 1-800-342-8017.
Para ayuda en Español, llame a 1-800-342-8017.
Si'w ta bezwen yon moun ki pale Kreyòl oswa yon moun ki pale Espanyòl ki pou ede'w, tanpri rele nan nimewo 1-800-342-8017.

It's Benefits Enrollment Time

Current Employee: A current employee is defined as an employee with active benefits.

New Employee: A new employee is defined as an employee without active benefits. If you are a new employee, you must enroll online by the due date stated in your benefits package. Otherwise, you will be automatically assigned to CIGNA Open Access Plus 20 (Employee only) coverage and Standard Short-Term Disability plan.

All employees who wish to make changes must re-enroll for 2011 benefits via the Internet. To enroll, log on to **www.dadeschools.net**. Click on the benefits "2011 Open Enrollment" button. You may access the following:

- 2011 Employee Benefits Guide
- Provider Directories
- Benefits Web Enrollment Form

Core Benefits

- The Board provides two healthcare plans: CIGNA OAP 20 and CIGNA OAP 10. OAP 20 is at no cost to the employee. OAP 10 does have an employee cost share determined by the employee's base salary. Please refer to Page 121 for the employee cost share and your dependent cost. (AFSCME employees are only eligible to enroll in OAP 20).
- All employees enrolling during the open enrollment of 11/17 /10 - 11/23/10 in the OAP 10 for January 1st will have the cost share deducted from the first 2011 Plan Year payroll of January 14th.
- All employees enrolling during the Open Enrollment Period of 2/16/11 - 3/1/11 in OAP 10 will have their first share deducted from the 3/28/11 paycheck.
- New hires after January 1, 2011, will continue to have their healthcare coverage effective the day of hire and will start paying for the cost share (only if enrolling in OAP10) on the first paycheck following the effective date of their healthcare coverage.
- The Board will continue to pay a portion of your dependent's healthcare coverage.
- You are provided with Board-paid Standard Short-Term Disability (STD) coverage.
- The School Board provides a Term Life and Accidental Death and Dismemberment (AD&D) program with

The materials contained in this guide do not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusions of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance and posted on the benefit Web site at **www.dadeschools.net**.

The School Board of Miami-Dade County, Florida reserves the right to amend or to terminate the Plans described in this guide at any time, subject to the specific restrictions, if any, in the collective bargaining agreement. In the event of any such amendment or termination, your coverage may be modified or discontinued and the School Board assumes no obligation to continue the benefits or coverages described in this guide.

This is a changes only enrollment.

IMPORTANT ENROLLMENT INFORMATION

- **If you do not want to make a change, you do not need to re-enroll during the Open Enrollment period. Your current benefits and those of your dependents will continue for the 2011 Plan Year at no additional cost.**
- **If you do not make changes and your salary has changed, your employee cost will automatically be adjusted.**
- **You must enroll if you want to make changes during this Open Enrollment period, change your healthcare or flexible benefits (i.e. Dental, Vision, etc.), or to add or delete your dependents. These changes become effective 4/1 and your changed deductions will be reflected in the 3/28 payroll.**

OPTING OUT OF HEALTHCARE

- **You may decline Board-Paid Healthcare coverage, provided you are enrolled in another group healthcare plan.**
- **In lieu of Board-Paid healthcare coverage, you will receive $100.00 a month paid through the payroll system (subject to withholding and FICA.**
- **If you do not provide proof of other group healthcare coverage, you will be automatically assigned the CIGNA Open Access Plus 20 (employee only) healthcare plan.**

TO ENROLL YOUR DEPENDENTS:

- **If you are adding new dependents, you will need to enter their Social Security Numbers on the Web enrollment application and you will need to submit dependent eligibility verification before the start of this plan year.**
- **If adding dependents for the first time, dependent documentation needs to be provided. If not, your dependents coverage will be terminated.**
- **An employee's dependent may now be covered under the employee's healthcare plan until the end of the calendar year they reach 26.**
- **To continue to cover your adult child dependent (ages 26-30), you must re-enroll and re-submit dependent eligibility documentation with your enrollment form. If dependent eligibility is not received, your current covered adult child will be cancelled December 31, 2010.**

Metropolitan Life Insurance Company for all full-time employees. The coverage amount is either one or two times your annual base salary rounded up to the next $1,000. Administrators and Confidential Exempt employees receive two times the annual base salary. All other employees receive one times their annual base salary. The minimum benefit for employees represented by AFSCME is $10,000. Additional life insurance may be purchased through payroll deduction to bring maximum benefits to an additional one times the amount provided by the School Board. You will be eligible to increase your coverage to a maximum of fives times the annual base salary after the first year of participation in the optional life program. Evidence of Insurability will be required for any increases in coverage. To find out more about Board-Paid Term Life and Accidental Death and Dismemberment, contact the MetLife Representative at 305-995-7029.

Benefits Update

Healthcare Coverage

The School Board of Miami-Dade County, Florida, is committed to providing you and your eligible dependents with the highest quality of benefit selections available. The following healthcare plans are being offered for the 2011 Plan Year:

- **CIGNA Open Access Plus (OAP) 10** – This is an open access plan that does not require you to choose a primary care physician. You may choose the physician of your choice. However, to receive your maximum benefit, you should select a doctor from the list of participating Open Access Plus providers.
  - There is a cost to you for this plan. This per pay check amount will be based on your base salary. NOTE: The deductions are not changing from 2010, unless your benefit salary has changed.
  - OAP 10 offers an in and out of network option at the time of service.
  - OAP 10 does not have an In-Network deductible.
  - OAP 10 has a co-insurance that applies for all services that do not have set co-pays.

- **CIGNA Open Access Plus (OAP) 20** – This is an open access plan that does not require you to choose a primary care physician. You may choose the physician of your choice. However, to receive your maximum benefit, you should select a doctor from the list of participating Open Access Plus providers.
  - Your School Board is contributing to your employee only coverage and there is no cost to you.
  - OAP 20 offers an in and out of network option at the time of service.
  - OAP 20 has a deductible.
  - OAP 20 has a co-insurance that applies for all services that do not have set co-pays.

Dependent Coverage for 2011

- **The School Board will continue to offset the cost of your dependent coverage significantly for 2011.**
- **Dependent Social Security numbers are required during Open Enrollment.** If your dependent's Social Security number is not provided, coverage for the dependent cannot be processed via the on-line enrollment. For additional information, call 1-800-342-8017.
- Documentation of your dependent's eligibility must be provided. Eligibility Documentation requirements can be found on pages 22-24.
- Children can include natural born children, stepchildren, adopted children and children for whom you have been appointed legal guardian. Your unmarried children are eligible from birth until the end of the year in which the child reaches age 26, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university. See also Adult Child on Page 25.
- Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is also included in the coverage.
- Dependent healthcare premiums will be taken on a post tax basis. Additionally, you must pay the tax liability on the monthly contribition (dependent subsidy) that the Board pays on your behalf.

Flexible Benefits

- Short-Term Disability coverage continues to be provided at no cost to you. In addition, the upgrades and LTD is also being offered.
- Miami-Dade County Public Schools will continue to offer a broad range of high-quality, elective benefits at very competitive prices, including:
  - Dental provider MetLife dental is offering MetLife SafeGuard DHMO, a comprehensive DHMO plan. You will need to choose your dental provider at the time you enroll. Your selected general dentist will refer you directly to a contracted specialty care provider; no additional referral or pre-authorization from SafeGuard, a MetLife Company, is required.
  - MetLife Indemnity Dental Plans continue to be offered.
  - Vision provider: UnitedHealthcare offers access to both private practice and retail chain providers that provide quality eye care and materials.
  - Choose from two Legal plans: The ARAG legal plan and the US Legal plan
  - Identity Theft Protection. ID Watchdog offers identity theft protection by verification of your identity, monitoring, detection and resolution of fraud.
  - Hospital Indemnity coverage
  - Short-Term Disability upgrades
  - Long-Term Disability
  - MetLife Term Voluntary Life insurance
  - MetLife Accidental Death and Dismemberment coverage.
  - Flexible Spending Accounts

- The Patient Protection and Affordable Care Act (PPACA) Healthcare Reform approved by congress and signed into law by President Obama changes the way some Over-the-Counter (OTC) items qualify for Flexible Spending Account (FSA) reimbursement. Beginning January 1, 2011, certain OTC drugs and medicines will no longer be eligible for reimbursement without a prescription from your attending provider. FBMC will continue to provide updates and post an updated OTC category list on this site as information becomes available. It's important to remember that you can still use your FSA funds for other eligible medical expenses and prescription purchases at pharmacies. Unaffected OTC items will still be reimburseable, as well as affected OTC items with a doctor's prescription. Please visit **www.myFBMC.com** for more information. If you have any questions regarding this new legislation, please contact FBMC Customer Care.

Evidence of Insurability (EOI)

If you are a current employee who chose not to enroll previously in Long-Term Disability or one of the Short-Term Disability buy up plans, **you must now complete an Evidence of Insurability (EOI) form before you are considered for coverage**. Existing employees currently enrolled in one of the Short-term buy up plans or Long-term plans and not making changes during this enrollment will continue with their current coverage. New hires do not need to provide EOI. Current employees electing this benefit during the 2011 Open Enrollment must complete an EOI form which will be verified by The Hartford. If your buy up or LTD EOI is approved, the effective date of this benefit will be the first of the month following your first payroll deduction.

NOTE: Your online confirmation notice will reflect a $0.00 deduction for this benefit which will change if your EOI is approved. The deduction will be taken on the last paycheck of the month after your approval, which makes your benefit effective the first of the following month after your first payroll deduction.

EOI forms will be distributed by The Hartford. For any questions, you may call a Hartford Representative at 1-800-741-4306.

Throughout the Plan Year

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

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MetLife Accidental Death and Dismemberment (AD&D) 111

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Important Phone Numbers and Hours of Operation

Enrollment Help Line
(305) 995-2777

Enrollment Web Site
24-hours/7 days a week
www.dadeschools.net

Enrollment Errors
FBMC Customer Care
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

HEALTHCARE PROVIDER

CIGNA
24-hours/7 days a week
1-800-806-3052
www.CIGNA.com

FLEXPLAN PROVIDERS

Dental Plans

SafeGuard MetLife DHMO Plans
Customer Service/Claims
Mon - Thur, 8 a.m. - 8 p.m. (All Zones)
Fri, 8 a.m. - 5 p.m. (All Zones)
1-800-880-1800
www.metlife.com/mybenefits

MetLife Indemnity Plans
Customer Service/Claims
Mon - Thur, 8 a.m. - 8 p.m. (All Zones)
Fri, 8 a.m. - 5 p.m. (All Zones)
1-800-942-0854
www.metlife.com/mybenefits

Life Insurance

MetLife Group Life Claims
Customer Service
305-995-7029
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-638-6420, option #2

Vision Plan

UnitedHealthcare Vision
Customer Service
Mon - Fri, 8 a.m. - 11 p.m. ET
Sat 9 a.m. - 6:30 p.m.
1-800-638-3120

Legal Plan

ARAG®
Customer Care
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-360-5567

ARAGLegalCenter.com,
Access Code: 10287mds

SeniorAdvocate™ Plan
ARAG Eldercare Program
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-360-5567
ARAGLegalCenter.com, Access Code: 10287mds

US Legal
Family Protector
Customer Service
1-800-356-LAWS
Available 24/7
www.uslprotects.com/members/family-protector/mdcps

Senior Protector
Customer Service
1-800-356-LAWS
Available 24/7
www.uslprotects.com/members/family-protector/mdcps

Short-term & Long-term Disability Plan

Hartford Life and Accident Insurance Company
Customer Service 305-995-4889
To File a Claim 1-800-741-4306
Medical Underwriting 1-800-331-7234
www.thehartfordatwork.com

Identity Theft Plan

ID Watchdog, Inc.
Customer Service
1-800-970-5182
Mon - Fri, 8 a.m. - 6 p.m. (MST)
www.idwatchdog.com

Hospital Indemnity Coverage

Life Insurance Co. of North America
(A CIGNA Company)
Customer Service/Claims
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

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

MetLife Voluntary Life Claims
Customer Service
305-995-7029
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-638-6420, option #2

Flexible Spending Accounts & myFBMC Card® Visa® Card

Fringe Benefits Management Company (FBMC)*
FBMC Customer Care Center
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017
1-800-955-8771 (TDD)

Automated Services
24 hours a day
1-800-865-FBMC (3262)
www.myFBMC.com

myFBMC Card®
Lost or Stolen Card
24 hours a day
1-888-462-1909

myFBMC Card® Activation
www.myfbmc.com

Dispute Line
FBMC Customer Care Center
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

VISTA 401(k)
VISTA Management Company
1-800-213-2310 - IVR
www.vmc.cc

OTHER IMPORTANT NUMBERS

For general benefit and enrollment information throughout the year

Miami-Dade County Public Schools
The Office of Risk and Benefits Management
Automated Phone System
Mon - Fri, 8 a.m. - 4:30 p.m. ET
(305) 995-7130
(305) 995-7190 FAX

Payroll Deduction Control
Automated Phone System
Mon - Fri, 8 a.m. - 4:30 p.m. ET
(305) 995-1655
(305) 995-1644 (FAX)

* Third Party Administrator for the M-DCPS fringe benefits program.

Florida KidCare
1-888-540-5437
www.floridacare.org

Enrollment Checklist

Document Preparation

Have the following supporting documentation on hand to help you successfully complete your online enrollment. Use the checklist below to prepare for your open enrollment.

Checklist to Enroll Online

- ✓ Your MDCPS Portal Username and Password
- ✓ Your Date of Birth
- ✓ Your Social Security Number
- ✓ Beneficiaries' Name
- ✓ Beneficiaries' Relationship
- ✓ Beneficiaries' Percentage of Coverage and Contingency
- ✓ Dependents' Name
- ✓ Dependents' Date of Birth
- ✓ Dependents' Relationship
- ✓ Dependent's VALID Social Security Number
- ✓ You and your dependents Primary Dental Provider (PDP) if selecting the Safeguard Standard or High Plan
- ✓ Disable the Pop-Up-Blocker on your computer to allow your Confirmation Notice to display at the end pof your enrollment session.
- ✓ Proof of dependent eligibility must be submitted to FBMC for all newly added dependent(s). Otherwise, coverage may be terminated for any dependent whose eligibility has not been verified, claims incurred will not be paid and any premiums deducted will not be automatically issued.

Before You Start Your Web Enrollment

Prior to enrolling in your benefits online, it is to your advantage to thoroughly review this reference guide. If you are ready to enroll, but need assistance, contact the Enrollment Help Line at (305) 995-2777 (to connect to the FBMC Customer Care Center). Once you have the answers you need, you may begin the enrollment process.

Before you begin your enrollment session it is important for you to disable the "Pop-Up-Blocker" of your computer. If you do not take this step, you will not be able to print your Confirmation Notice at the close of your enrollment session.

Your District Account Status

Prior to accessing your Employee Portal, you need to be aware of the status of your District account and the process for accessing Open enrollment information.

Different situations will apply:

1. If you actively used your district account to access the portal or District e-mail within the past 180 days, NO ACTION IS NECESSARY. Your access will remain the same.
2. If you have not used your District account in more than 180 days to access the portal or District e-mail, your account is inactive. On Monday, November 9, 2010, Information Technology Services (ITS) will reactivate your account. After the reactivation occurs, you will have access using the following login credentials:
   - **Username - Your Employee Number (Example - 123456)**
   - **Password - Your birth month (2 digits), birth year (4 digits) and your first name initial and last name initial (Example: 011952DG).**
3. If you have never used your District account to access the portal or District e-mail, your account is inactive. On Monday, November 9, 2010, ITS will reactivate your account. After the reactivation occurs, you will have access using the following login credentials:
   - **Username - Your Employee Number (Example: 123456)**
   - **Password - Your birth month (2 digits), birth year (4 digits) and your first name initial and last name initial (Example: 011952DG)**
4. For all reactivated accounts, once your account is active and you attempt to sign on, you will be required to change your password using the District's Password Management tool, P-Synch. Instructions for this process and to reset can be found at **http://www.dadeschools.net/passwordreset/passReset.asp?lang=en-us**.

1 How to Log On

Log on to the Miami-Dade County Public Schools homepage at **www.dadeschools.net** and click on the following buttons:

Current Employees:

- 2011 Open Enrollment button, then the
- log onto the Employee Portal

New Employees:

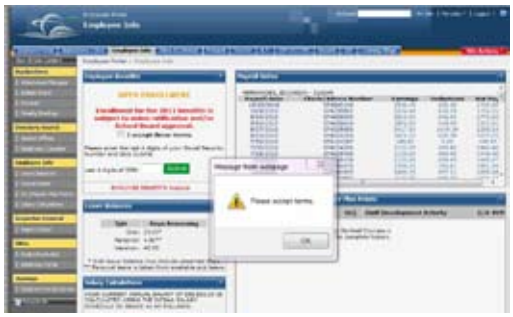
- Employee TAB
- 2011 New Employee Benefits enrollment button

2 Enter your Login Username and Password

NOTE: The first time you log in, enter your Employee Number and password (Check your **District Account Status** on the previous page for password details).

Password - Your birth month (2 digits), birth year (4 digits) and your first name initial and last name initial (Example: 011952DG)

Once logged in, click on the "**Employee Info**" tab at the top of the page.



3 MDCPSPS Employee info Page

You will be prompted to fill in the last 4 digits of your Social Security Number, then click the green "Submit" button.

4 Select PremierEnroll

You will automatically be logged into myFBMC.com. Click the "2011 Benefits Enrollment" link in myFBMC to access PremierEnroll.

5 Begin your Open Enrollment

Once you are logged in to PremierEnroll, click the "Open Enrollment – Benefits 2011" link to start your enrollment.

6 Verify your Demographic Information

Begin your enrollment by verifying your demographic information. If you need to update your address, you may do so through the Employee Sefl Service (ESS) of SAP at the Empoloyee Portal at the **www.dadeschools.net** home page.

Click the "Start Benefit Election" button to begin benefit selection for your dependents. Note the following important information regarding dependent information:

- Dependent Social Security numbers are required during Open Enrollment. If your dependent's SSN is not provided, your dependent's coverage cannot be processed.
- Review and update any incorrect dependent information.

Once your demographic information is correct, click on the "Start Benefit Election" button.

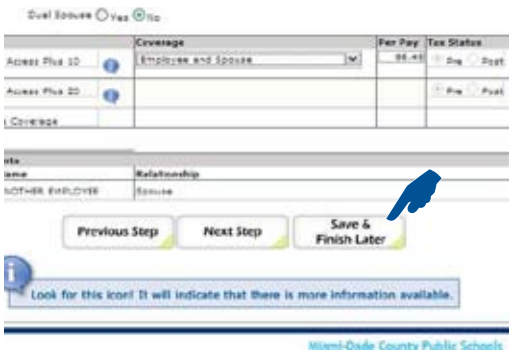
7 Select Employee Healthcare Coverage

If you are a current employee who is eligible for Healthcare coverage, you will see the screen at the right. Choose your Healthcare plan and type of coverage or decline medical coverage. Select dependent coverage after you select your healthcare plan or decline healthcare coverage.

For the OAP 10 Plan, the rate displayed includes your Cost Share amount, which is dependent on your base salary. Note: If you do not succesfully complete your enrollment information before the Open Enrollment deadline, your 2010 benefits will continue and your cost share will automatically be adjusted.

To decline School-Board provided Healthcare benefits, you must select to decline Healthcare coverage and agree to the provision set forth on the affidavit. If you decline healthcare coverage, you will receive $100 a month, subject to withholding and FICA taxes.

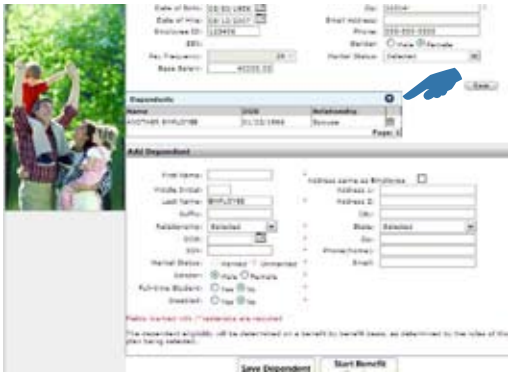
NOTE: If you do not finish your enrollment, your 2010 Benefits will continue. If you experienced a change in salary band, your employee cost will be automatically adjusted.



8 Dependent Healthcare Coverage

If your dependents had benefits coverage during the 2010 Plan Year, review the listed dependent(s) on this screen for accuracy and be sure all dependent Social Security numbers and birth dates are correct. Add new dependents and their SSN as necessary, or to delete a dependent, click on the "trash" icon to the right of the dependent's name.

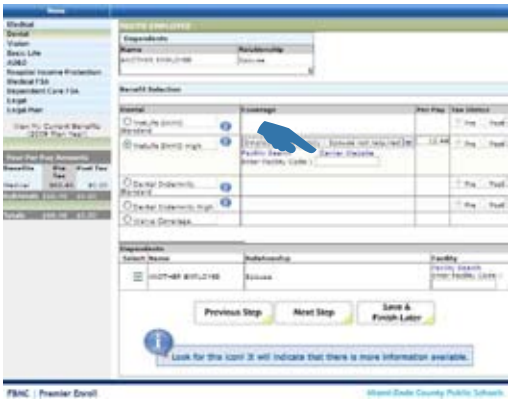
If you are selecting Life Insurance, enter your Beneficiary Information on this screen.



NOTE: If you are covering the children of your Domestic Partner, you must also cover your Domestic Partner. Select "Employee and Family with Domestic Partner" under

9 Dental Coverage

If you select SafeGuard, a MetLife company, Dental HMO Plan, you must enter a **Primary Dentist Facility Number.** If you do not know the facility number, you can enter "9999" to assign coverage without a facility number.



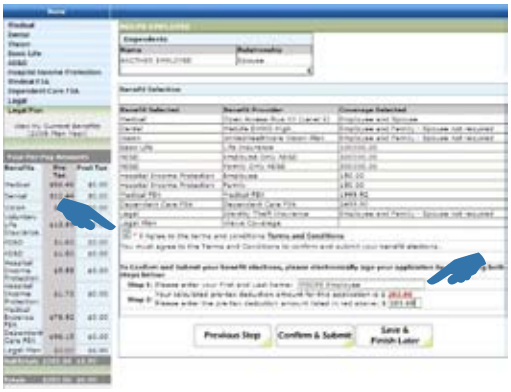
10 Review Your Employee Benefits Summary

After you have filled in all your enrollment information, review your selections on the Summary of Benefits Selection Page.

In order for your selections to be saved, you **MUST** complete all of the following:

- Agree to the terms and conditions (Check the box.)
- Enter your name for Step 1.
- Verify and enter the pre-tax deduction amount for Step 2 (Deductions are post tax, as displayed).

If you do not complete these steps, your 2010 benefits will be continued and the cost share for OAP 10 will automatically be adjusted.



11 Saving Your Enrollment Record

Once you have reviewed your Benefits Summary and verified that all information is correct, **then click the "Confirm & Submit" button.**

A confirmation notice is automatically generated and presented at the end of your enrollment session. Any prior enrollment session can have a reprinted confirmation notice using the "Enrollment History" link. In addition, if you meet with an enroller, you will be given a printout.

PRINT THIS PAGE FOR YOUR RECORDS

12 Review Your Confirmation Statement

You can view and print your Confirmation Statement immediately after you have saved your benefit selections. You will not receive another printed Confirmation Statement. Please print a copy for your own records.

Sample Electronic Confirmation Statement

Upon printing your Confirmation Statement, review it carefully for accuracy. Any benefit changes must be made online. **After your enrollment deadline, enrollment changes will be on an appeals basis only.**

Current employees: To appeal an enrollment selection, you must go to the Office of Risk and Benefits Management at 1501 NE 2nd Avenue. Suite 335 in person by December 3, 2011, before the beginning of the Plan Year.

No faxes or phone calls are accepted.

NOTE: If your Confirmation Statement does not match your enrollment selections, please contact the FBMC Customer Care Center at 1-800-342-8017, 7 a.m. to 10 p.m. ET. **Current Employees:** Requests for all corrections, changes or appeals must be made prior to the commencement of the plan year. **NO EXCEPTIONS WILL BE ALLOWED.**

New employees: Requests for all corrections or changes must be made within seven days of receiving your Confirmation Statement.

You may make changes to your online selections as many times as you wish until the end of your enrollment period. However, make sure to close all windows prior to re-enrolling to avoid errors on selections saved.

If you enroll multiple times, your enrollment selection for the 2011 Plan Year will be your last submission.

Open Enrollment Facts for Current Employees

1. What is the Open Enrollment Period? The Open Enrollment Period is a period of time, determined by your employer, during which you are allowed to make any changes to your benefits.

NOTICE: No changes are allowed after the commencement of a new plan year (see Page 27 for the Change in Status section for exceptions).

2. Must all eligible employees enroll for benefits effective January 1, 2011? No.This is a changes only enrollment. If you do not re-enroll during the Open Enrollment period, your current benefits and those of your dependents will continue for the 2011 Plan Year. If you have an Adult Child currently covered under CIGNA, coverage will terminate at the end of the plan year. You must re-enroll your Adult Child for 2011 benefits and re-submit documentation. If you are opting out of M-DCPS healthcare, you must provide documentation of other group healthcare coverage. If you currently cover or plan to cover your dependent(s), including domestic partners, you must provide their Social Security Number and dependent eligibility verification before the start of this plan year. Please refer to Pages 22-24 for a complete list of documents.

3. What is my effective date when enrolling during the enrollment period of 2/15/11 - 3/1/11? The effective date for these benefits is 4/1/11.

4. If I am hired during this Open Enrollment period, must I enroll for the current plan year as well as the next plan year? No. You must enroll for both plan years if you are making a change for Plan Year 2011. If not, the benefits you are enrolled for in 2010 will continue for the 2011 Plan Year.

5. What changes can I make during the Open Enrollment? During this period, you may purchase benefits, delete or add dependents. Any dependent child who is 26 in the year 2010 (born in 1984)* cannot be covered or be added for 2011 Benefits during the Open Enrollment period as a regular dependent. See Page 25 for new provision for adult dependents. If a covered dependent is disabled, proof must be submitted in order for coverage to continue beyond 26 years of age.

6. How will I know when to enroll? You will be permitted to enroll during your Bargaining Unit's Open Enrollment period. You will receive an e-mail specifying your Bargaining Unit's enrollment dates.

7. When is the last day to enroll for benefits effective, January 1, 2011? You must complete your online enrollment selections by midnight on 11/23/10. The last day for the Open Enrollment period of 2/15/11 - 3/1/11 must be completed by 3/1/11.

8. What happens if I do not enroll by the enrollment deadline? This is a changes only enrollment. If you do not re-enroll during the Open Enrollment period, your current benefits and those of your dependents will continue for the 2011 Plan Year

9. What if I do not have a computer or Internet access available? If you do not have access to the Internet, you may visit the Office of Risk and Benefits Management for assistance at 1501 NE 2nd Avenue, Conference Suite 335. Enrollment Assistance is available weekdays from 8 a.m. to 5:00 p.m., during this Open Enrollment period.

10. What if I enroll and I want to change my benefits selection? You may log on to the Internet and change your benefits selection as many times as you want throughout the Open Enrollment period. Your last **saved** and **submitted** selection will be your benefits effective January 1, 2011. Changes made during the Open Enrollment period of 2/15/11 - 3/1/11 will be effective 4/1/11.

11. Can I decline any of the Employer-Paid benefits? Yes. You may decline Healthcare coverage. However, you must **agree** to the provision set forth on the affidavit. Refer to Page 52.

12. If I decline Healthcare coverage, what happens to the Board contribution toward my benefits? In lieu of Board-Paid Healthcare coverage, you will receive $100 per month paid through the payroll system (Subject to withholding and FICA).

13. Can I select coverage for myself through one Healthcare Plan and another for my family? No. You and your family must be covered with the same Healthcare Plans.

14. Can I select coverage for myself through one FlexPlan benefit and another for my family? No. You and your family must be covered with the same FlexPlan benefit and provider.

15. How do I view the CIGNA Healthcare or FlexPlan Provider Directories? Go to the 2011 Benefits Open Enrollment Button and click on the Provider Directory of the company you desire. See Page 25 for new provision for adult dependents.

Confirmation of Benefits

16. Will I receive a confirmation of my 2011 benefits selection? Yes. Everyone will be able to view and print their Confirmation Statement online immediately after benefit selections are saved successfully. If you would like to review your confirmation statement after the enrollment period, please re-login to the Online Enrollment Web site. From the main menu, click on the ""Enrollment History" link and reprint your Confirmation Statement.

A confirmation notice is automatically generated and presented at the end of your enrollment session. Any prior enrollment session can have a reprinted confirmation notice using the "Enrollment History" link. In addition, if you meet with an enroller, you will be given a printout.

Effective Date of Coverage

17. When are benefits for the new plan year effective and for how long? Your benefits become effective on January 1, 2011, and continue through December 31, 2011 as long as full-time employment is continued.

Changes made during the Open Enrollment Period of 2/15/11 - 3/1/11 become effective 4/1/11 and will continue through 12/31/11 as long as your full-time employment continues.

Termination Date

Should employment terminate, coverage will cease at the end of the calendar month in which employment terminates. Benefits will remain in effect through August 31 for 10-month employees who terminate employment during the last month of the school year.

Open Enrollment Facts For New Employees

1. Must all new employees enroll? Yes. You must complete your enrollment by logging on to **www.dadeschools.net**.

2. What is the deadline for completing my online enrollment? The deadline date is indicated on the cover memo in your benefits package. Enrolling in this time frame will ensure that you receive the benefits of your choice.

3. Can I elect not to be covered? Yes. You may elect to waive your Healthcare coverage, providing you agree to comply with the Healthcare Declination Affidavit on Page 52. In lieu of Healthcare coverage, you will receive $100 per month paid through the payroll system (subject to withholding and FICA). If you want to Opt-out of the M-DCPS provided healthcare plans, you must provide proof of other group healthcare coverage. If you do not provide proof of other group coverage, you will be automatically enrolled in CIGNA Open Access Plus 20 Employee Only coverage.

4. What if I do not enroll? If you do not complete your enrollment in the allotted time:

- You will automatically be assigned to CIGNA Open Access Plus 20 (employee only) healthcare plan and no dependent healthcare.
- You will automatically receive Standard Short-Term Disability coverage at a maximum of $500 per week and Life Insurance either one or two times your annual base salary (amount is decided per your Bargaining Contract).
- You will not have any flexible benefits (i.e. dental, legal, etc.) and no dependent coverage.
- These benefits will be effective for the remainder of the plan year as long as your full-time employment with Miami-Dade County Public Schools continues.

5. What if I do not have a computer or Internet access available? If you do not have access to the Internet, you may visit the Office of Risk and Benefits Management for assistance at 1501 NE 2nd Avenue, Suite 335, weekdays from 8:00 a.m. to 4:30 p.m. ET.

6. What if after I enroll I want to change my benefits selection? You may change your benefits selection as many times as you wish until the end of your initial enrollment period.

7. Can I select coverage for myself through one Healthcare plan benefit and another for my family? No. You and your family must be covered with the same Healthcare plans.

8. Can I select coverage for myself through one FlexPlan benefit and another for my family? No. You and your family must be covered with the same FlexPlan benefit and providers.

9. How do I view the CIGNA or FlexPlan Provider Directories? Go to the Employee Benefits button at www.dadeschools.net. Under the Active Employees, click on 2011 Benefits and then on the and click on the Provider Directory resources link you desire.

Confirmation of Benefits

10. Will I receive a confirmation statement of my 2011 benefits selection? Yes. Everyone will be able to view and print their Confirmation Statement online immediately after benefit selections are saved successfully. If you would like to review your confirmation statement after the enrollment period, please re-login to the Online Enrollment Web site. From the main menu, click on the "Confirmation Statement" link. You will be able to view and print your most recent enrollment benefit selections.

A confirmation notice is automatically generated and presented at the end of your enrollment session. Any prior enrollment session can have a reprinted confirmation notice using the "Enrollment History" link. In addition, if you meet with an enroller, you will be given a printout.

Effective Date of Coverage

11. When are benefits effective and for how long? Healthcare benefits are effective on the first day of full-time employment. Board-Paid Short-Term Disability will be effective on the first of the month following your first day of employment. If you elect OAP 10, cost share deductions start the next available payroll after the effective date.

Employee-paid benefits are effective the first of the month following your first payroll deduction.

Termination Date

Should employment terminate, coverage will cease at the end of the month in which employment terminates. Benefits will remain in effect through August 31 for 10-month employees who terminate employment during the last month of the school year.

Who Is Eligible for Coverage*

Who is an eligible dependent? An eligible dependent is defined as:

SPOUSE: Your spouse is considered your eligible dependent for as long as you are lawfully married.

DOMESTIC PARTNER: Your Domestic Partner is eligible for coverage as long as he/she:

- is of the same or opposite sex
- shares your permanent residence
- has resided with you for no less than one year
- is no less than 18 years of age and is not related to you by blood in a manner that would bar marriage under applicable state laws
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements:
- joint mortgage or lease for a residence
- joint ownership of a motor vehicle
- joint bank or investment account, joint credit card or other evidence of joint financial responsibility
- a will and/or life insurance policies which designates the other as primary beneficiary, beneficiary for retirement benefits, assignment of durable power of attorney or health care proxy.

To add a Domestic Partner, an employee must register, under applicable state or municipal laws or provide a duly sworn Affidavit of Domestic Partnership confirming the eligibility above. In addition, the definition of domestic partner will be met as long as neither partner:

- Has signed a domestic partner affidavit or declaration with any other person within 12 months before designating each other as domestic partner
- Is not legally married to another person, or
- Does not have any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

NOTE: A Domestic Partner and the child(ren) of a Domestic Partner are eligible. They do not qualify for IRS Section 125. All employee-paid benefits will be on a post-tax basis. Additionally, you must pay the tax liability on the monthly contribition (dependent subsidy) that the Board pays on your behalf. Domestic Partners or their child(ren) who do not meet the eligibility criteria, will have benefit(s) coverage terminated and any claims incurred will not be paid. All other selected employee-paid benefits will continue for the remainder of the plan year on a post-tax basis. The Domestic Partner must also be included in that coverage. Domestic Partners and/or their children do not qualify as eligible dependents for FSA Reimbursement.

CHILDREN: Children can include natural born children, stepchildren, adopted children and children for whom you have been appointed legal guardian. Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is also included in the coverage.

- For Healthcare, Dental and Vision benefits: your dependent is eligible for coverage through the end of the year that they turn 26. Coverage applies whether they are/are not married or is/is not a student. For the full definition of an eligible child, view the FSA FAQs at **www.myFBMC.com**.
- For all other benefits, your unmarried children are eligible from birth until the end of the year in which the child reaches age 25, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university.

NEWBORN CHILDREN: A natural born child, adopted child, the child of your Domestic Partner, or a child for whom you have been appointed legal guardian who is born or becomes eligible while a policy is in effect will be covered from date of birth/event. However, coverage is not automatic. You must request a Change In Status Election form within 30 days of the event and add your newborn child(ren)'s information.

NOTE: Your newborn will be covered free of charge for the first 31 days. However, You must call and request a Change in Status (CIS) form within the 30 days for coverage to become active.

- If you request your dependent's coverage be terminated within the first 31 days, the termination is effective the day you request it, but or no later than the 31st day, You will have to submit your cancellation in writing.
- If you do not submit your dependent's termination of coverage in writing, your dependent will remain actively enrolled and you will be billed from the 32nd day. You will pay the daily newborn rate till the day prior to the next available payroll, then you will pay the full prepay deduction.
- If you add your dependent after the 31st day but within 60 days from birth/event, your dependent will be effective retroactive to the day of birth and the you will be charged the full prepay deduction.

DISABLED CHILDREN: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the plans. However, if coverage is terminated, it cannot be reinstated even during Open Enrollment. Proof of disability (Social Security disability papers) must be provided to FBMC - 1501 NE 2nd Avenue, Suite 335, Miami, FL 33132.

GRANDCHILDREN: A newborn child of a covered dependent is eligible from birth until the end of the month in which the child reaches 18 months of age. However, if the parent becomes ineligible during the grandchild's 18 months eligibility period, coverage for both the parent and the child will terminate.

NOTE: Hospital Indemnity Plan Coverage offered by LINA **does not** cover grandchildren.

ADULT CHILD: Rules governing dependent coverage have changed. A provision in the new Patient Protection and Affordable Care Act (PPACA) Healthcare Reform allows for an employee's dependent to be covered under the employee's healthcare plan until they reach age 26. However, the School Board will continue to provide coverage for regular dependents until the end of the calendar year in which they reach the age of 26. The dependent will be deemed an Adult Child the following calendar year. For the full definition of an eligible child, view the FSA FAQs at **www.myFBMC.com**. Under Florida law, a dependent adult child ages **26 – 30** may be considered an eligible dependent for the purpose of "health" insurance.

For medical coverage offered under the M-DCPS plan, you may add or continue to cover your dependent until the end of the calendar year in which the child reaches the age of 26-30, if the adult child:

- Is dependent upon you for support;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

In addition, the following dependent eligibility documents must be submitted with your completed enrollment form prior to the adult child dependent being added to your healthcare coverage:

- Affidavit of Eligibility (enclosed in this package)
- Birth certificate or court documents of adoption/ guardianship/legal custody
- Social Security Number
- Driver License

NOTE: A currently covered adult child will not automatically remain covered for next year, they must be re-enrolled.

Flexible Spending Accounts

Whose medical expenses can I include in my Medical Expense FSA? You can include medical expenses you paid for your spouse or dependent. A person generally qualifies as your dependent for purposes of the medical expense deduction if:

1) That person lived with you for the entire year as a member of your household or is related to you
2) That person was a U.S. citizen or resident, or a resident of Canada or Mexico for some part of the calendar year in which your tax year began, and
3) You provided over half of that person's total support for the calendar year. You can include the medical expenses of any person who is your dependent, even if you cannot claim an exemption for him or her on your return. Domestic Partners and their children are ineligible.

NOTE: The Patient Protection and Affordable Care Act (PPACA) Healthcare Reform approved by congress and signed into law by President Obama changes the way some Over-the-Counter (OTC) items qualify for Flexible Spending Account (FSA) reimbursement. Beginning Jan. 1, 2011, certain OTC drugs and medicines will no longer be eligible for reimbursement without a prescription from your attending provider. FBMC will continue to provide updates and post an updated OTC category list on this site as information becomes available. It's important to remember that you can still use your FSA funds for other eligible medical expenses and prescription purchases at pharmacies. Unaffected OTC items will still be reimburseable, as well as affected OTC items with a doctor's prescription or Letter of Medical Need. Please visit **www.myFBMC.com** for more information. If you have any questions regarding this new legislation, please contact FBMC Customer Care.

Whose dependent care expense can I include in my Dependent Care FSA? Your child and dependent care expenses must be for the care of a qualifying person.

A qualifying person is:

1) Your dependent child who is 12 years of age or younger when the care was provided and for whom you can claim an exemption,
2) Your spouse who was physically or mentally not able to care for himself or herself, or
3) Your dependent who was physically or mentally not able to care for himself or herself and for whom you can claim an exemption. See the Dependent Care FSA section of this guide for more details.

A partial list of eligible dependent care expenses, include:

- babysitting fees
- day care services
- elder care services
- summer day camps

Additional information is found on Page 61.

NOTE: This account cannot be used to pay for dependent healthcare premiums. This is not dependent healthcare, but a reimbursement account for dependent care expenses.

Online Claims Submission Instructions

Follow these simple instructions to submit your completed claim form and supporting documentation online through **www.myFBMC.com**. Instructions are also available online, or contact FBMC's Customer Care Center for assistance.

Please note:

- Acceptable document formats are .jpg, .bmp or .gif.
- Individual file sizes cannot exceed 1 megabyte.
- Be sure to have your completed claim form and supporting documentation scanned before beginning the process. Refer to your scanner's instruction manual for information on saving your documents in the proper format and within the acceptable file size limit.

How to Submit your claim:

1. To use FBMC's Online Claims Submission process, you must first log in to your account at **www.myFBMC.com**.
2. Once you have logged in, click on the "Claims" tab at the top of the screen, then choose "Online Claims Submission" from the drop down menu.
3. From here, simply follow the online instructions:
   - Choose the account type for which you are submitting a claim.
   - Enter the dollar amount of the claim in the appropriate box.
   - Click "Next".
4. Follow the instructions on the next page:
   - Attach your completed and signed claim form.
   - Attach your supporting documentation (receipts, invoices, etc).
   - Click "Submit".
5. Be sure to write down the confirmation number for future reference. If you receive any errors or the confirmation page does not load, it is possible that the file sizes of your scanned documents exceeds 1 megabyte or they are not the appropriate document format. Double-check the file sizes and make adjustments if necessary by rescanning the oversized documents and making sure they are .jpg, .bmp or .gif files. Contact FBMC's Customer Care Center if you have any questions.

Effective Date of Coverage

1. When are benefits for the new plan year effective and for how long? Current employee benefits become effective on January 1, 2011 of this plan year and continue through December 31, 2011 as long as full-time employment is continued. Should employment terminate, coverage will cease at the end of the calendar month in which employment terminates. Benefits will remain in effect through August 31 for 10-month employees who terminate employment during the last month of the school year.

NOTICE: An individual who loses coverage under the plan becomes entitled to elect COBRA. The individual has the right to continue his or her medical, dental and vision coverage under COBRA law for a period of 18 months and/or Medical Expense FSA deposits until the end of the plan year following termination of employment. The individual must notify the COBRA Specialist at the Office of Risk and Benefits Management.

COBRA

2. When should I drop my dependent child who reaches age 26? If your dependent child reaches age 26 in the 2011 Plan Year (born in 1985), coverage for the ineligible dependent will be terminated at the end of the plan year.

Claims will not be paid nor will premiums be automatically refunded for ineligible dependents:

However, you may continue to cover your adult child until the end of the calendar year in which the child reaches the age of 30, if the child:

- Does not have a dependent of his or her own
- Is a resident of Florida, and
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.
- In addition, currently covered adult children who are turning age 30 in 2011 are eligible for COBRA and a package will be sent. If your currently covered adult child is still eligible, you must re-submit your adult child's documentation. Your adult child may enroll for 2011.
- Currently covered adult children will also receive a COBRA enrollment package.

DISABLED CHILDREN: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the plans. However, if coverage is terminated, it could never again be reinstated. Proof of disability must be provided to FBMC - 1501 NE 2nd Avenue, Suite 335, Miami, FL 33132.

3. How can my qualified dependent continue coverage under medical, dental or vision plans? Within 30 days from the date of loss of eligibility, your qualified dependent must notify the COBRA Representative in the Office of Risk and Benefits Management at (305) 995-1285, (305) 995-7137 or (305) 995-1738. A qualifying event notice and an application will be forwarded to the qualified dependent within 30 calendar days.

4. How long does the qualified dependent have to make his/her COBRA elections? The qualified dependent has a 60-day period to elect whether to continue coverage. Once a qualified dependent has elected COBRA, he/she has 45 days to pay for the coverage. COBRA is retroactive if elected and paid for by the qualified dependent.

5. What are the periods of coverage for COBRA qualifying events? If the qualifying event is the employee's termination of employment, the employee, spouse, and dependent child are eligible for COBRA for up to 18 months; if the event is a divorce or death of a covered employee, the spouse and dependent child are eligible for coverage for up to 36 months; and if the event is loss of a "dependent child" status, the dependent child is eligible for 36 months.

You may elect to continue your Medical Expense FSA and continue to receive reimbursements through the end of the plan year. To continue your Medical Expense FSA, contact a COBRA Representative at (305) 995-7169, (305) 995-1738 or (305) 995-7137.

Board-Approved Leave of Absence

6. If I take a Board-approved leave of absence, whom do I contact about my benefits? Once your leave is approved and the Office of Risk and Benefits Management receives notification, you will be eligible for applicable benefits according to your Bargaining Unit and type of leave. You will be billed for any employee-paid benefits.

Miami-Dade County Public Schools implements the Family and Medical Leave Act of 1993 (FMLA) through provisions contained in the School Board Rules and collective bargaining agreement.

For questions regarding your benefits while on leave, please call 305-995-7129 and ask to speak with a leave billing specialist.

7. What if I am unable to pay premiums while on leave? The benefits for which you have been billed will be cancelled if payment is not received by the due date and any claims incurred will not be paid unless otherwise provided by law.

Employer-paid benefits will be automatically reinstated upon your return to work. However, in order to reinstate any employee-paid benefits cancelled due to non-payment while on leave, you must request a Change in Status Election form. See the Changes in Status event information on Page 27 for further details.

Benefits at Retirement

8. If I retire, whom do I contact for benefits information? When you complete your retirement papers, the Retirement Office will notify the Office of Risk and Benefits Management and a package will be mailed to your home containing the information you need to continue your Healthcare coverage, life insurance benefits and flexible benefits plans after you retire. You will have 30 days to select your benefits. Only those dependents which were covered under your medical and flexible benefits plan at the time of your retirement will be eligible to continue coverage. You may add or drop dependents during the annual Open Enrollment for retirees. You may only continue life insurance and accidental death and dismemberment at the same level in effect at your retirement. If you retire while on a leave of absence and have no active healthcare and/or flexible benefits at retirement, you will not be eligible to enroll in any benefits not in effect. You may contact the Office of Risk and Benefits Management at 305-995-7129 for questions.

Termination of Employment

9. Does my insurance coverage end when I terminate my employment? Benefits for you and your dependents continue to the end of the calendar month in which you terminate employment. However, benefits for 10-month employees who terminate at the end of the school year remain in effect through August 31, provided they work during the last month of the school year.

10. Can I continue my own and my dependents' medical, dental and vision coverage if I terminate employment? Yes. According to federal and state law, you can continue your own and/or your dependents' coverage for a period of 18 months following a termination of employment by applying for COBRA. You will be notified of these rights when you terminate; or you can call the Office of Risk and Benefits Management at (305) 995-1285, (305) 995-7137 or (305) 995-7169. and speak to a COBRA Representative to inquire further on what benefits will be available to you.

11. Can I continue my Board Life insurance if I terminate? You may apply for a conversion policy for all or any portion of your or your dependents' life insurance in effect at termination. You must complete a conversion application, which is available from Metropolitan Life Insurance Company by calling (305)-995-7029 within 31 days of termination.

12. What happens to my FSA contributions if I terminate employment or retire? If you terminate employment or retire, your FSA contributions will stop with the pay period preceding your last day of employment and use of your Payment Card will be suspended.You cannot continue to submit expenses incurred after your **benefits end date** for reimbursement from your Medical Expense FSA unless you continue to make post-tax contributions to your account through COBRA. Eligible Dependent Care expenses incurred after **termination of employment** are reimbursable until funds in your account are exhausted.

Remember, you have until April 15, 2012, to submit a request for reimbursement for expenses incurred before your **benefits end date**. See the Flexible Spending Accounts section of this guide for more details.

Claims and Claim Forms

13. What claim form must I complete for my dental and vision benefits? Claim forms are available at the Office of Risk and Benefits Management or online at www.dadeschools.net., and click on Employee Benefits, then on the Claim Form link.

14. When do I request a claim form for my Short-Term and Long-Term Disability? The Hartford must receive notification no later than 90 days after your elimination period. You must notify The Hartford at 1-800-741-4306.

How does the Flexible Benefits Plan affect other benefits?

15. Your Retirement Benefits

Your contributions to the FlexPlan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS.

Tax Sheltered Annuity

Participating in the FlexPlan does not affect your Tax Sheltered Annuity (TSA) contribution. That is, FlexPlan contributions do not reduce includable compensation* from which the maximum deferrable amount is computed under the 403(b) plan.

*Includable compensation is the gross income shown on your W-2 form.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors', and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call the FBMC Customer Care Center at 1-800-342-8017 for an approximation.

Itemized Deductions

The portion of your salary set aside for benefit premiums and FSAs through the FlexPlan will not be included in the taxable salary reported to the IRS on your W-2 form. However, your contributions to your Dependent Care FSA will appear on your W-2 form for informational purposes only. You will not have to claim these payments as deductions at the end of the year. Your pre-tax FlexPlan reductions cannot be used as itemized deductions for income tax purposes at the end of the year.

Pre-tax/Post-tax

Employees who wish to have their 2011 premiums deducted POST-TAX may do so by indicating so during their enrollment. If a selection is not made, applicable deductions and employer contributions will continue on a pre-tax basis. Regardless of your selection, Flexible Spending Accounts are always PRE-TAX. Your Legal Plan, SeniorAdvocate Plan, and Long-Term Disability (LTD) are always POST-TAX.

When an employee elects pre-tax deductions, all employee-paid premiums will be taken prior to federal withholding tax. All benefits are subject to pre-tax deductions except those that are not exempt from taxation — Legal Coverage, LTD and the SeniorAdvocate Program. When an employee elects post-tax deductions, all employee-paid premiums will be taken after federal withholding tax has been taken. All benefits are subject to post-tax deductions except those that are exempt from taxation.

If you elect to upgrade your Board-Paid Standard Short-Term Disability plan, your premiums will be deducted on a PRE-TAX basis and you will receive a W-2 form for the calendar year in which benefits were paid. However, if your premiums were paid on a POST-TAX basis, benefits paid to you will not be taxed. The premiums paid by the School Board for the Standard Short-Term Disability plan will be on a PRE-TAX basis.

Employees who elect coverage for Domestic Partners and their dependents will automatically have post-tax deductions on all employee-paid benefits except those that are exempt from taxation. Additionally, you must pay the tax liability on the monthly contribution (dependent subsidy) that the Board pays on your behalf. Should the Domestic Partner coverage be denied, all benefits will continue on a post-tax basis except those that are exempt from taxation.

**** Please see each product page for specific dependent eligibility information. Eligibility for healthcare, dental, and vision will be verified by the contract administrator, Fringe Benefits Management Company. For a list of required documentation, see Page 22. If proof is not submitted by 12/31/10, the dependent coverage will be terminated and claims will not be paid. If dependent coverage is terminated and premiums were deducted, refunds will not be automatically issued. To request a refund, if applicable, contact Payroll Deduction Control at 305-995-1655. All other benefits will be verified by the individual insurance company at the**

Dependent Eligibility Documentation Requirements

Dependent Relationship	Documentation Requirements
Spouse	Marriage Certificate
Natural Child	Birth Certificate (must list employee as a parent) **NOTE:** birth registration, SS card or passport is not valid proof
Stepchild	Birth Certificate (must list employee's spouse as a parent) and Marriage Certificate.
Adopted Child	Court Documentation of adoption
Legal Custody or Guardianship	Court documentation defining guardianship or legal custody. **NOTE:** Notarized affidavit is not acceptable documentation
Disabled Dependents Over Age 26	Social Security Disability Documentation. Disabled dependents are eligible only if covered by a School Board Healthcare plan or Flexible Benefits plan prior to the date of disability. Additionally, if coverage is terminated, it cannot be reinstated.
Adult Child (between the age of 26 - 30)	• Affidavit of Eligibility • Birth certificate or Court Documents of Adoption/guardianship/legal custody • Proof of Florida Residence (Florida Driver License)

Dependent Eligibility Documentation

Return To: School Mail: WL 9112, Suite 335

US Mail: Office of Risk & Benefits Management, 1501 NE 2nd Avenue, Suite 335, Miami, FL 33132

Fax To: 305-995-1425

Employee Number _____

Social Security Number _____

Employee Name _____

Important Information

- Proof of eligibility must be on file for all listed dependents.
- If proof was not submitted to FBMC previously or if you are adding new dependents, you must submit proof of eligibility with your enrollment form. Otherwise, coverage may be terminated for any dependent whose eligibility has not been verified. Claims incurred will not be paid and any premiums deducted will not be automatically issued. You must request a refund, if applicable, from Payroll Deduction Control.
- **Print, complete and include this form with the required documentation.**
- If not previously submitted, you must provide your covered dependent's Social Security number.

DEPENDENT NAME (print clearly) Last Name	First Name	MI	BIRTH DATE	SOCIAL SECURITY #	RELATIONSHIP	GENDER	DOCUMENT PROOF INCLUDED (birth certificate, marriage certificate, etc.)

Employee Signature _____ Date _____

Domestic Partner Eligibility Documentation Requirements

Relationship	Documentation Requirements
Domestic Partner A copy of the Domestic Partnership Affidavit is available on the Open Enrollment Web site at www.dadeschools.net.	Affidavit of Domestic Partnership and any two of the following: • Joint mortgage or lease of residence • Joint ownership of a motor vehicle • Joint bank or investment account • Joint credit card or other financial responsibility • Will naming the partner as the beneficiary • Life Insurance policy naming the partner as the beneficiary • Assignment of durable power of attorney or healthcare proxy
Children of Domestic Partner	Birth Certificate (must list Domestic Partner as a parent) and Domestic Partner documentation as defined above. **NOTE:** Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner with children" coverage.
Grandchildren of Domestic Partner	Birth Certificate (must list Domestic Partner's child as a parent) and children of Domestic Partner documentation as defined above. **NOTE:** Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner with children" coverage. Legal Custody or Guardianship documentation

Important Information

Proof of eligibility must be provided for Domestic Partner and all listed Children or Grandchildren of Domestic Partner (Include this form with the required documentation).

Employee Number _____

Employee Name _____

Social Security Number _____

PRINT AND RETURN BY U.S. MAIL TO:

Office of Risk & Benefits Management
1501 NE 2nd Avenue, Suite 335
Miami, FL 33132

RETURN BY SCHOOL MAIL TO:

Work Location 9112, Suite 335

Indicate the relationship of your dependent on the form below.

DP = Domestic Partner **DC** = Child of Domestic Partner **DGC** = Grandchild of Domestic Partner

DEPENDENT NAME (print clearly) Last Name First Name MI	**BIRTH DATE**	**SOCIAL SECURITY #**	**RELATIONSHIP**	**GENDER**	**DOCUMENT PROOF INCLUDED** (birth certificate, joint mortgage, etc.)

Employee Signature_____ Date_____

FBMC/M-DCPS/1110

Affidavit of Domestic Partnership

The undersigned, being duly sworn, depose and declare as follows:

- We are each eighteen years of age or older and mentally competent.
- We are not related by blood in a manner that would bar marriage under the laws of the State of _____.
- We have a close and committed personal relationship, and we are each other's sole domestic partner not married to or partnered with any other spouse, spouse equivalent or domestic partner.
- For at least one year we have shared the same regular and permanent residence in a committed relationship and intend to do so indefinitely.
- We have provided true and accurate required documentation of our relationship.
- Each of us understands and agrees that in the event any of the statements set forth herein are not true, the insurance or Healthcare coverage for which this Affidavit is being submitted may be rescinded and/or each of us shall jointly and severally be liable for any expenses incurred by the employer, insurer or Healthcare entity.
- I understand that, per IRS Section 125, all deductions for employee-paid benefits will be taken on a post-tax basis.
- I understand that I must pay the tax liability on the monthly contribution (dependent subsidy) that the Board pays on my behalf.

_____	_____
Print Name	Print Name
_____	_____
Signature	Signature

Sworn to before me this _____ day of_____ , 20 _____ .

_____

NOTARY PUBLIC

Return To: School Mail:
WL 9112
Suite 335

US Mail:
Office of Risk & Benefits Management
1501 NE 2nd Avenue., Suite 335
Miami, FL 33132

Fax To: 305-995-1425

Important Notice!!!

In order to continue coverage of your currently enrolled Adult Child, you must re-enroll and re-submit the dependent eligibility documentation by the November 23, 2010 enrollment deadline.

Rules governing dependent coverage have changed. A provision in the new Patient Protection and Affordable Care Act (PPACA) Healthcare Reform allows for an employee's dependent to be covered under the employee's healthcare plan until they reach age 26. However, the School Board will continue to provide coverage for these dependents until the end of the calendar year in which they reach the age of 26. The dependent will be deemed an Adult Child the following calendar year. For the full definition of an eligible child, view the FSA FAQs at **www.myFBMC.com**. Under Florida law, a dependent adult child ages 26 – 30 may be considered an eligible dependent for the purpose of "health" insurance.

For medical coverage offered under the M-DCPS plan, you may add or continue to cover your Adult Child until the end of the calendar year in which the adult child reaches the age of 26-30, if the adult child:

- Is dependent upon you for support;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

In addition, the following dependent eligibility documents must be submitted with your completed enrollment form prior to the adult child dependent being added to your healthcare coverage:

- Affidavit of Eligibility
- Birth certificate or court documents of adoption/guardianship/legal custody
- Social Security Number
- Driver License

NOTE: To continue to cover your adult child dependent, you must re-enroll and re-submit dependent eligibility documentation with your enrollment form. If dependent eligibility is not received, your current covered adult child will be cancelled December 31, 2010.

Adult Dependent Healthcare Premiums:

CIGNA HEALTHCARE	MONTHLY RATE PER ADULT DEPENDENT CHILD
Open Access Plus (OAP) 20	$415.00
Open Access Plus (OAP) 10	$452.00

NOTE: If you are covering other children, your adult child must be covered under the same healthcare plan, and the adult dependent premium is in addition to the under age 26 children rate.

To request an Adult Dependent enrollment package, call FBMC at 800-342-8017, M-F, 7 AM to 10 PM. An enrollment form and Affidavit of Eligibility will be mailed to your home address the following business day. Your completed form, affidavit, and dependent eligibilty documentation must be received by the due date noted on the form.

Can I add or delete dependent coverage and make changes in my benefit elections during the year?

A participant is permitted to make changes to his or her elections mid-plan year only for a legitimate Change in Status (CIS). Meaning, "on account of and corresponding with a Change in Status that affects eligibility for coverage." If you experience a qualifying CIS Event, the election changes must be requested within 30 days from the qualifying event and the change must be consistent with the type of event. However, you cannot change your medical or dental plan insurance provider. You may add dependents to your existing coverage or delete your dependents. Please refer to the Change in Status events information on Page 27 of this guide.

If I experience a CIS event, how and when must I request the CIS form in order for the change to be approved?

You must call Fringe Benefits Management Company at 1-800-342-8017 within **30 days** from the date of the valid event and request a Change In Status Election Form.

Documentation supporting the Change in Status must be submitted with the form. **Requests made after the 30th day from the valid event date and forms and documentation received after the due date, will not be granted. You will have to wait until the following annual Open Enrollment period to make any changes to your benefits.**

When I add dependents through a CIS event, when do their benefits become effective?

Coverage for your dependents becomes effective on the 1st of the month following your first payroll deduction, except for newborns** and adopted dependents. Your newborn dependents are covered from their date of birth; adopted dependents are covered effective the date of placement. Documents validating the CIS event and dependent's eligibility are required at time of request.

** Your newborn will be covered free of charge for the first 31 days. **Your newborn child is not automatically enrolled by your employer or group health plan.** You must add your newborn dependent within 30 days, even if your current coverage includes employee and children, or employee and family coverage or employee and Domestic Partner and their child(ren). Don't forget to include the proper documentation when adding a dependent. See Page 16 through 27 of this guide for more details.

- If you request your dependent's coverage to be terminated within the first 31 days, the termination is effective the day you request it, or no later than the 31st day.
- If you do not request to terminate your dependent, your dependent will remain actively enrolled and you will be billed from the 32nd day. You will pay the daily newborn rate till the day prior to the commencement of the next available payroll, then you will pay the full premium.
- If you add your dependent after the 31st day but within 60 days from birth, coverage will be effective retroactive to the day of birth and you will be charged the full premium.

When I delete a dependent through a Change In Status, when does their coverage terminate?

Coverage for your dependent(s) is terminated effective the last day of the month after receipt of a completed Change in Status Form and supporting documentation.

NOTE: Any 10-month employee submitting a Change in Status Form after the end of the school year will have the form processed with a benefits termination date of August 31.

If I decline School Board Healthcare coverage, but I lose my other coverage, can I re-enroll under a School Board plan mid-year?

You may only enroll in a School Board Healthcare plan mid-year if you have lost other **group** insurance coverage. Supporting documentation will be required.

Domestic Partners and their Child(ren)

The Internal Revenue Service (IRS) Section 125 "Change In Status: Rules and Guidelines" does not apply. An employee may terminate their Domestic Partners and/or child(ren) at any time of the year, but may not reinstate their coverage until the following Open Enrollment period (effective January 1 of the following plan year) as long as all of the eligibility criteria has been met again. An employee may add their Domestic Partner if eligibility requirements are met during the plan year or due to loss of other group coverage.

An employee and their Domestic Partner must sign an Affidavit of Domestic Partnership which states that the employee and domestic partner are:

- Each eighteen years of age or older and mentally competent
- Have a close and committed personal relationship, and are each other's sole domestic partner not married to or partnered with any other spouse, spouse equivalent or domestic partner
- Have provided true and accurate required documentation of their relationship, and
- Each understands and agrees that in the event any of the statements set forth on the affidavit are not true, the insurance or health care coverage for which the Affidavit is being submitted may be rescinded and/or each shall jointly and severally be liable for any expense incurred by the employer, insurer or health care entity.
- Employee-paid benefits will be taken on a post-tax basis.
- Emploee must pay tax liability on the monthly contribution (dependent subsidy) that the Board pays toward dependent coverage.

PLEASE REFER TO PAGE 27 OF THIS GUIDE FOR CHANGE IN STATUS EVENTS.

Mid-Year Benefit Changes In Status (CIS)

Forms must be requested within 30 days from the date of the event listed below. You must contact FBMC at 1-800-342-8017 for a CIS election form. Appropriate documentation supporting the Change in Status Event is required when returning the form.

Marital Status

A change in marital status includes marriage, death, divorce or annulment (legal separation is not recognized in the State of Florida).

Change in Number of Eligible Dependents

A change in number of dependents *includes* the following: birth, death, adoption and placement for adoption and change in marital status. Existing eligible dependents can also be added whenever a dependent gains eligibility as a result of a valid CIS event.

Change in Status of Employment Affecting Coverage Eligibility

Change in employment status of the employee, or a spouse or dependent of the employee that affects the individual's eligibility under an employer's plan; such as commencement or termination of employment.

Gain or Loss of Dependents' Eligibility Status

An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan due to: attainment of age; student status; marital status; employment status.

Change in Residence

A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan, such as moving out of the network service area (except for Medical Expense FSAs).

Open Enrollment Under Other Employer's Plan

You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if*:

- their employer's plan year is different from your employer's plan year,
- they participate in their employer's plan, and
- their employer's plan permits mid-plan year election changes under this event.

* Does not apply to a Medical Expense FSA.

Judgement/Decree/Order

If a judgement, decree or order from a divorce, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a grandchild who is your dependent), you may change your election* to provide coverage for the dependent child. If the Order requires that another individual (including your spouse and former spouse) cover the dependent child and provide coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.

*Does not apply to Dependent Care FSA.

Medicare/Medicaid/Kidcare

Gain or loss of Medicare/Medicaid eligibility and enrollment may trigger a permitted election change. Documentation indicating effective date of event and affected dependents must be presented with CIS form.

HIPAA

If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC Sec. 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a **pre-tax** basis, effective retroactive to the date of the CIS event, **if you enroll your new dependent within 30 days** of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is **not** subject to HIPAA's special enrollment provisions if it is funded **solely** by employee contributions.

Other Election Changes

Domestic Partner and their children: The Internal Revenue Service (IRS) Section 125 "Change in Status" rules and guidelines do not apply. An employee may terminate coverage for their Domestic Partner and/or their child(ren) at any time of the year, but may not reinstate their coverage until the following Open Enrollment Period (effective January 1 of the following plan year) as long as all of the eligibility criteria has been met once again. You may add a dependent if eligibility requirements are met during the plan year or due to loss of alternative group coverage.

Summary of Benefits

Your CIGNA HealthCare Open Access Plus plan

Features that Add Value

- Your plan offers the convenience of **referral-free** access to doctors, and the option to select a **personal Primary Care Physician (PCP)** as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information Line℠ connects you to **trained nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- CIGNA *Healthy Rewards®* includes special offers on health and wellness programs and services often not covered by many traditional benefits plans. Just call 1.800.870.3470 or visit our web site at **www.cigna.com**.
- Prescription drug coverage is a **part of your plan**. With national and independent pharmacies participating across the country, you can have your prescription filled wherever you go. CIGNA Tel-Drug gives you quick, convenient delivery of your medications right to your home.

Quality Service Is Part of Quality Care

- **Service** is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.cigna.com** – Visit our **interactive Web** site to learn more about your plan and get health information, 24 hours a day. Once you enroll, register for **myCIGNA.com**, our convenient, secure web site that combines helpful easy-to-use tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages℠** . We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.

It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our **health and wellness** programs:

- We encourage you to use a **PCP** as a valuable resource and personal health advocate.
- **Preventive care services** for your children through age 16 and any additional preventive care benefits described in the Benefits Highlights.
- **CIGNA Well Informed** provides members with customized medical and wellness information to help them make healthier choices, better understand a diagnosis or treatment, and manage their health. The program includes personalized letters and other educational information to help you improve your health. Only you, your doctor and CIGNA have access to this information.
- CIGNA Well Aware for Better Health® can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies® program provides you with information to help you have a **healthy pregnancy** and **a healthy baby**.

You Can Depend on CIGNA HealthCare

- **Quality comes first.** We select "preferred providers" carefully. And we make sure you have a **wide range** of doctors to choose from.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**. Urgent care centers can take care of your urgent care needs, and your cost is lower.

It's Your Choice

- When you visit network providers, you get access to quality care at the lowest out-of-pocket costs. Your plan also offers the freedom to choose the providers you prefer — even if they aren't part of the network. Your benefits are the highest when you see "preferred providers," but you're still covered for visits to other providers. Participating providers charge a discounted rate for CIGNA members. If you use a non-network provider, the provider may bill you for the difference between the billed charge and the allowed amount under your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

Open Access Plus (OAP) 20 and Open Access Plus (OAP) 10 - CIGNA National Network (Open Access Plus) Platform

	OAP 20 Plan		OAP 10 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFIT INFORMATION				
Calendar Year Plan Deductible Individual / Family Maximum	$250 / $500	$1,000 / $2,000	None / None	$500 / $1,000
Calendar Year Out-of-Pocket Maximum Individual / Family Maximum	Excluding Plan Deductible $1,500 / $3,000	Excluding Plan Deductible $6,000 / $12,000	$1,500 / $3,000	Excluding Plan Deductible $3,000 / $6,000
Coinsurance	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.	CIGNA HealthCare pays 60% of eligible charges. You pay 40% of charges after plan deductible.	CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges.	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible.
Precertification -Inpatient – PHS+ (required for all inpatient admissions)	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/ reduction or denial for noncompliance.	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/ reduction or denial for noncompliance.
Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/ reduction or denial for non-compliance.	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/ reduction or denial for non-compliance.
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Pre-existing Condition Limitation	No	No	No	No
BENEFIT HIGHLIGHTS				
Physician Services **Primary Care Physician (PCP) Office Visit**	$20 copayment per office visit	40% of charges**	$20 copayment per office visit	30% of charges**
Specialty Physician Office Visit Consultant and Referral Physician Services	$40 copayment per office visit	40% of charges**	$40 copayment per office visit	30% of charges**
Allergy Treatment/Injections - PCP or Specialty Physician	$20 or $40 copayment per office visit or actual charge, whichever is less	40% of charges**	$20 or $40 copayment per office visit or actual charge, whichever is less	30% of charges**
Allergy Serum (dispensed by physician in office)	No charge	40% of charges**	No charge	30% of charges**
Second Opinion Consultations (provided on voluntary basis)	$20 or $40 copayment per office visit	40% of charges**	$20 or $40 copayment per office visit	30% of charges**
Surgery Performed in the Physician's Office- PCP or Specialty Physician	$20 or $40 copayment per office visit	40% of charges**	$20 or $40 copayment per office visit	30% of charges**
Preventive Care Routine Preventive Care for Children to age 16 (including routine immunizations)	$20 or $40 copayment per office visit	40% of charges	$20 or $40 copayment per office visit	30% of charges
Immunizations	No charge, no plan deductible	40% of charges**	No charge	30% of charges**
Routine Preventive Care for Children and Adults from age 16 (including routine immunizations) Unlimited maximum per calendar year	$20 or $40 copayment per office visit	Covered in-network	$20 or $40 copayment per office visit	Covered in-network
Immunizations	No charge, no plan deductible	Covered in-network only	No charge	Covered in-network only
Annual Well Woman Exam	$20 copayment per office visit	40% of charges**	$20 copayment per office visit	30% of charges**

All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Services are subject to calendar year deductible

** Out-of-network services are subject to calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

\# In-network and out-of-network services apply to the same treatment or dollar maximum.

CIGNA Healthcare Comparison Chart

	OAP 20 Plan		OAP 10 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Mammograms	No charge, no plan deductible	No charge, no plan deductible	No charge	No charge, no plan deductible
Diagnostic Mammograms Outpatient Facility – Hospital Based	No charge, no plan deductible	40% of charges**	No charge	30% of charges**
Diagnostic Mammograms Outpatient Facility – Non-Hospital Based	No charge (no copay applied)	40% of charges**	No charge (no copay applied)	30% of charges**
PSA, and Pap Tests	$20 or $40 copayment per office visit	40% of charges**	$20 or $40 copayment per office visit	30% of charges**
Inpatient Hospital Services including: Semi-Private Room and Board, Diagnostic/Therapeutic Lab and X-ray, Drugs and Medication, Operating and Recovery Room, Radiation Therapy and Chemotherapy, Anesthesia and Inhalation Therapy, MRIs, MRAs, CAT Scans, PET Scans, etc.	20% of charges*	40% of charges* Precertification required	10% of charges	30% of charges* Precertification required
Inpatient Hospital Doctor's Visits/ Consultations	20% of charges*	40% of charges**	10% of charges	30% of charges**
Inpatient Hospital Professional Services	20% of charges*	40% of charges**	10% of charges	30% of charges**
Outpatient Facility Services – Hospital Based - includes: Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including: Diagnostic/Therapeutic Lab and X-rays, Anesthesia and Inhalation Therapy	20% of charges*	40% of charges**	10% of charges	30% of charges**
Outpatient Facility Services – Non-Hospital Based	$100 copayment per facility visit	40% of charges**	$100 copayment per facility visit	30% of charges**
Physician & Outpatient Professional Services	No charge, no plan deductible	40% of charges**	No charge	30% of charges**
Laboratory Services (includes preadmission testing)				
Physician's Office	$20 or $40 copayment per office visit	40% of charges**	$20 or $40 copayment per office visit	30% of charges**
Outpatient Hospital Facility	No charge, no plan deductible	40% of charges**	No charge	30% of charges**
Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)	No charge	No charge; except if not a true emergency, then 40% of charges**	No charge	No charge; except if not a true emergency, then 30% of charges**
Independent Lab Facility	No charge, no plan deductible	40% of charges**	No charge	30% of charges**
Radiology Services ***(includes pre-admission testing)***				
Physician's Office	No charge after PCP or Specialist per visit copay	40% after plan deductible	No charge after PCP or Specialist per visit copay	30% after plan deductible
Outpatient Hospital Based Facility	20%, after deductible	40% after plan deductible	10%, after deductible	30% after plan deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge	No charge (except if not a true emergency, then 40% after plan deductible)	No charge	No charge (except if not a true emergency, then 30% after plan deductible)
Independent X-ray facility (non-hospital based)	100% after $100 copay per visit	40% after plan deductible	100% after $100 copay per visit	30% after plan deductible

All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Services are subject to calendar year deductible

** Out-of-network services are subject to calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

\# In-network and out-of-network services apply to the same treatment or dollar maximum.

CIGNA Healthcare Comparison Chart

	OAP 20 Plan		OAP 10 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)				
Inpatient Facility	20% of charges*	40% of charges**	10% of charges	30% of charges**
Outpatient Facility- Hospital Based	20% of charges*	40% of charges**	10% of charges	30% of charges**
Outpatient Facility- Non-Hospital Based	$100 scan copayment	40% of charges**	$100 scan copayment	30% of charges**
Emergency Room (billed by facility as part of the Emergency Room visit)	No charge	No charge; except if not a true emergency, then 40% of charges**	No charge	No charge; except if not a true emergency, then 30% of charges**
Physician's Office ***Note:*** *The scan copayment will be administered on a per type of scan per day basis*	$100 scan copayment	40% of charges**	$100 scan copayment	30% of charges**
Short-Term Rehabilitative Therapy and Cardiac Rehabilitation Services (includes cardiac rehab, physical, speech, occupational & pulmonary rehab therapy) 40 days maximum per calendar year# per each therapy ***Note:*** *therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.*	$20 or $40 copayment per office visit	40% of charges**	$20 or $40 copayment per office visit	30% of charges**
Chiropractic Care 30 days maximum per calendar year# **Office Visit**	$40 copayment per office visit	40% of charges**	$40 copayment per office visit	30% of charges**
Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician	$20 or $40 copayment per office visit	Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 40% of charges**	$20 or $40 copayment per office visit	Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 30% of charges**
Hospital Emergency Room	$200 copayment per visit (copay waived if admitted)		$200 copayment per visit (copay waived if admitted)	
Hospital Emergency Room – JMH Facilities	$100 copayment per visit (copay waived if admitted)		$100 copayment per visit (copay waived if admitted)	
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	No charge		No charge	
Urgent Care Facility or Outpatient Facility	$50 copayment per visit (copay waived if admitted)		$50 copayment per visit (copay waived if admitted)	
Convenience Care Clinics	$20 copayment per facility visit		$20 copayment per facility visit	
Ambulance	$50 copayment		$50 copayment	
Maternity Care Services Initial Office Visit to Confirm Pregnancy ***Note:*** *A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.*	$20 or $40 copayment for initial office visit	40% of charges**	$20 or $40 copayment for initial office visit	30% of charges**
All subsequent Prenatal Visits, Postnatal Visits	No charge	40% of charges**	No charge	30% of charges**
Obstetrical/Midwifery – Physician's Delivery Charges (i.e. global maternity fee)	20% of charges*	40% of charges**	10% of charges	30% of charges**
Office Visits not included in the total maternity fee performed by OB or Specialty Physician	$20 or $40 copayment per office visit	40% of charges**	$20 or $40 copayment per office visit	30% of charges*
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	20% of charges*	40% of charges*, precertification required	10% of charges	30% of charges*, precertification required

All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Services are subject to calendar year deductible

** Out-of-network services are subject to calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

\# In-network and out-of-network services apply to the same treatment or dollar maximum.

CIGNA Healthcare Comparison Chart

	OAP 20 Plan		OAP 10 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities 90 days maximum per calendar year# combined for all facilities listed	20% of charges*	40% of charges**	10% of charges	30% of charges**
Home Health Services – Includes outpatient private duty nursing when approved as medically necessary 16 hour maximum per day#	$20 copayment per day	40% of charges**	$20 copay per day	30% of charges**
Family Planning Services				
Office Visits (lab & radiology tests, counseling)	$20 or $40 copayment per office visit	Covered in-network only	$20 or $40 copayment per office visit	Covered in-network only
Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility	20% of charges*	Covered in-network only	10% of charges	Covered in-network only
Outpatient Facility – Hospital Based Outpatient Facility – Non-Hospital Based	20% of charges* $100 copayment per facility visit	Covered in-network only Covered in-network only	10% of charges $100 copayment per facility visit	Covered in-network only
Physician's Services – Inpatient Physician's Services – Outpatient	20% of charges* No charge, no plan deductible	Covered in-network only Covered in-network only	10% of charges No charge	Covered in-network only
Physician's Office	$20 or $40 copayment per office visit	Covered in-network only	$20 or $40 copayment per office visit	Covered in-network only
Infertility Services				
Office Visit (lab & radiology tests, counseling)-PCP or Specialty Physician	$20 or $40 copayment per office visit	Covered in-network only	$20 or $40 copayment per office visit	Covered in-network only
Treatment/Surgery (excludes artificial insemination, invitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility	20% of charges*	Covered in-network only	10% of charges	Covered in-network only
Outpatient Facility – Hospital Based Outpatient Facility – Non-Hospital Based	20% of charges* $100 copayment per facility visit	Covered in-network only Covered in-network only	10% of charges $100 copayment per facility visit	Covered in-network only
Physician's Services - Inpatient Physician's Services - Outpatient	20% of charges* No charge, no plan deductible	Covered in-network only Covered in-network only	10% of charges No charge	Covered in-network only
TMJ - Surgical and Non-Surgical-case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.				
Physician's Office	$20 or $40 copayment per office visit	40% of charges**	$20 or $40 copayment per office visit	30% of charges**
Inpatient Facility	20% of charges*	40% of charges*, precertification required	10% of charges	30% of charges*, precertification required
Outpatient Facility – Hospital Based Outpatient Facility – Non-Hospital Based	20% of charges* $100 copayment per facility visit	40% of charges** 40% of charges**	10% of charges	30% of charges**
Physician's Services - Inpatient Physician's Services - Outpatient	20% of charges* No charge, no plan deductible	40% of charges** 40% of charges**	10% of charges No charge	30% of charges** 30% of charges**
Bariatric Surgery				
Physician's Office	Not covered	Not covered	$20 or $40 copayment per office visit	Covered in-network only
Inpatient Facility			10% of charges	Covered in-network only
Outpatient Facility – Hospital Based			10% of charges	Covered in-network only
Outpatient Facility – Non-Hospital Based			$100 copayment per facility visit	Covered in-network only
Physician's Services - Inpatient Physician's Services - Outpatient			10% of charges No charge	Covered in-network only Covered in-network only

All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Services are subject to calendar year deductible

** Out-of-network services are subject to calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

\# In-network and out-of-network services apply to the same treatment or dollar maximum.

	OAP 20 Plan		OAP 10 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health				
Inpatient –Unlimited maximum per calendar year	20% of charges*	40% of charges*	10% of charges	30% of charges*
Outpatient Mental Health (includes Individual, Group Therapy and Intensive Outpatient services) – Unlimited maximum per calendar year	$20 copayment per office visit	40% of charges**	$20 copayment per office visit	30% of charges**
Outpatient Facility – Hospital Based Outpatient Facility – Non-Hospital Based	20% of charges* $100 copayment per facility visit	40% of charges** 40% of charges**	10% of charges $100 copayment per facility visit	30% of charges** 30% of charges**
Note: *Non-surgical treatment procedures (including Intensive Outpatient) are not subject to the outpatient facility copayment or outpatient facility deductible.*				
Substance Abuse				
Inpatient – Unlimited maximum per calendar year	20% of charges*	40% of charges*	10% of charges	30% of charges*
Outpatient Substance Abuse (includes Individual and Intensive Outpatient services) – Unlimited maximum per calendar year	$20 copayment per office visit	40% of charges**	$20 copayment per office visit	30% of charges**
Outpatient Facility – Hospital Based Outpatient Facility – Non-Hospital Based	20% of charges* $100 copayment per facility visit	40% of charges** 40% of charges**	10% of charges $100 copayment per facility visit	30% of charges** 30% of charges**
Note: *Non-surgical treatment procedures (including Intensive Outpatient) are not subject to the outpatient facility copay or outpatient facility deductible.*				
Durable Medical Equipment Unlimited maximum per calendar year	$100 copayment per item per year	40% of charges**	$100 copayment per item per year	30% of charges**
External Prosthetic Appliances Unlimited maximum per calendar year	$100 copayment per item per year	40% of charges**	$100 copayment per item per year	30% of charges**
Consumable Medical Supplies *(Example: ostomy supplies, oxygen, etc.)*	20% of charges*	40% of charges**	10% of charges	30% of charges**
Prescription Drugs				
CIGNA Pharmacy Retail Drug Program Generic*** drugs on the Prescription Drug List for a 30-day supply	$10 copayment per prescription/refill	40% of charges, no plan deductible	$10 copayment per prescription/refill	30% of charges, no plan deductible
Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30- day supply	$30 copayment per prescription/refill	40% of charges, no plan deductible	$30 copayment per prescription/refill	30% of charges, no plan deductible
Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 30-day supply	$50 copayment per prescription/refill	40% of charges, no plan deductible	$50 copayment per prescription/refill	30% of charges, no plan deductible
CIGNA Tel-Drug Mail Order Drug Program Generic*** drugs on the Prescription Drug List for a 90-day supply	$20 copayment per prescription/refill	Covered in-network only	$20 copayment per prescription/refill	Covered in-network only
Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90- day supply	$60 copayment per prescription/refill	Covered in-network only	$60 copayment per prescription/refill	Covered in-network only
Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 90-day supply	$100 copayment per prescription/refill	Covered in-network only	$100 copayment per prescription/refill	Covered in-network only
***Designated as per generally-accepted industry sources and adopted by CG.				
Please note: If a brand name drug, for which a generic exists is determined to be medically necessary, the retail cost of that drug is $50; Home Delivery cost is $100. To be eligible, your physician must submit evidence of medical necessity though the CIGNA Pharmacy appeal process. *The Appeal Form is found on the MDCPS Benefit Website.*				

All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Services are subject to calendar year deductible

** Out-of-network services are subject to calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

\# In-network and out-of-network services apply to the same treatment or dollar maximum.

Footnotes:

Regarding In-Network and Out-of-Network Services:

- Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, including Mental Health and Substance Abuse services

Regarding In-Network Services:

- All services must be provided by one of the preferred providers on our list in order to be covered.

Regarding Out-of-Network Services:

- Your out-of-pocket costs will be higher than with a preferred provider.
- All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.

Case Management

Coordinated by CIGNA HealthCare. This is a service designed to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Benefit Exclusions.

These are examples of the exclusions in your plan. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control.

1. Any service or supply not described as covered in the Covered Expenses section of the plan.

2. Any medical service or device that is not medically necessary.

3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.

4. Any services and supplies for or in connection with experimental, investigational or unproven services.

5. Dental treatment of the teeth, gums or structures directly supporting the teeth, however, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.

6. This exclusion applies only to the OAP20 plan. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35–39 with comorbidities. The following are specifically excluded: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.

7. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

8. Court ordered treatment or hospitalizations.

9. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.

11. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.

12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.

13. Consumable medical supplies other than ostomy supplies and urinary catheters.

14. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.

15. Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).

17. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

18. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan.

19. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.

20. Genetic screening or pre-implantation genetic screening.

21. Fees associated with the collection or donation of blood or blood products.

22. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.

24. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

25. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.

26. Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.

27. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; Macromastia or Gynecomastia Surgeries; Surgical Treatment of Varicose Veins unless medically necessary; Abdominoplasty/Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant Skin Surgery; Removal of Skin Tags; Acupressure; Craniosacral/cranial therapy; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolfing; Prolotherapy; Transsexual Surgery; Non-medical counseling or ancillary services; Assistance in the activities of daily living; Cosmetics; Personal or Comfort Items; Dietary Supplements; Health and Beauty Aids; Aids or devices that assist with non-verbal communications; Treatment by Acupuncture; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

These Are Only the Highlights

As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.

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Dollars & Sense – *Easy ways to decrease your out-of-pocket healthcare expenses*

If it's not an emergency… or even urgent

In this case, it's best to go to your own primary care physician's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You also pay the least amount when you receive care in a doctor's office. In addition, experienced Care24 nurses are always available to provide immediate answers to your and your family's health questions, 24 hours a day, every day of the year by calling 1-800-806-3052.

Primary Care Physician co-pay by Plan:

OAP 20 Plan	OAP 10 Plan
$20	$20

Convenience Care Centers

Sometimes, Convenience Care Centers can be a great alternative to seeing your regular physician for simple health care services. "Convenience Care Center" earned their nickname because they are located in some retail stores (selected MinuteClinic at CVS and Take Care Health Clinics at Walgreens) for convenient access. They are open 7 days a week, and weeknights too. Visits don't require an appointment, and the cost is consistent with your Primary Care Physician co-pay. Staffed by nurse practitioners and physician assistants, these centers offer an alternative to scheduling a doctor's office appointment for a range of simple services to patients 18 months and older. These may include common infections like bronchitis, bladder, ear, pink eye, or strep throat – and skin conditions like athlete's foot, cold sores, minor sunburn or poison ivy.

Convenience Care Centers co-pay by Plan:

OAP 20 Plan	OAP 10 Plan
$20	$20

To find a Convenience Care Center near you log on to CVS at **http://www.minuteclinic.com** or Walgreens at **http://www.takecarehealth.com.** If you do not have access to the Internet, you may call MinuteClinic at (866) 825-3227 or Take Care Clinic at (866) 825-3227.

I can't wait for my regular doctor… Urgent care

Sometimes, you need more than simple medical care fast, but the emergency room may not be necessary. A great alternative is an urgent care center, where you can get treated for many minor problems faster than at an emergency room and pay less than an Emergency Room visit.

Urgent Care Facility co-pay by Plan:

OAP 20 Plan	OAP 10 Plan
$50	$50

To find an Urgent Care Facility near you, log on to **http://www.myCIGNA.com** or **CIGNA.com**. If you do not have access to the internet, you may call CIGNA Customer Service at 1-800-806-3052.

Emergency Room

If you believe you or your loved one may be experiencing an emergent medical condition, you should go to the nearest emergency room or call for emergency assistance (such as 911). Examples of emergent medical conditions may include (but are not limited to): fractures, heavy bleeding, large open wounds, sudden change in vision, chest pain, sudden weakness or trouble walking, major burns, spinal or severe head injuries or difficulty breathing. This is not an exhaustive list and you should not hesitate to access emergency services and care if you believe you or your loved one may be experiencing an emergent medical condition.

***Emergency Room co-pay by Plan:**

OAP 20 Plan	OAP 10 Plan
$200	$200

* Emergency Room co-pay is waived if admitted. $100 copay in JMH facilities (Memorial, North, South and Cedars/UM Hospitals)

Use the CIGNA Network Using doctors, hospitals and facilities that participate in the CIGNA network can save you a lot of money. "In-network" services apply to all health care services, including doctors and hospitals, as well as outpatient testing, treatment and surgery centers that are participating in the CIGNA network. Additionally, the CIGNA Care Network, a special group of designated in-network doctors and facilities who have met stringent quality and cost criteria, may offer additional value and savings. To verify that a doctor or facility is in CIGNA's network and the CIGNA Care Network, check our provider directory on **myCIGNA.com** or **CIGNA.com**, or call the number on the back of your CIGNA ID card.

Laboratory and Pathology Tests Two of the nation's largest laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the CIGNA network. Services at these labs can cost 70-75% less than the same services provided by hospital-based facilities and other laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check our provider directory on **myCIGNA.com** or **CIGNA.com**. You can also contact Quest or LabCorp directly by phone or visit their websites:

- Quest: 800-377-7220 / web: www.questdiagnostics.com
- LabCorp: 888-522-2677 / web: **www.labcorp.com**

Radiology Services (MRI or CT Scan) If you need to have an MRI or CT scan, you can save hundreds of dollars by considering an independent radiology center (stand alone)instead of a hospital setting. While CIGNA contracts with all type of facilities, including hospitals and outpatient radiology centers, cost can vary greatly depending on where you have your MRI or CT scan (contact CIGNA for precertification requirements). Discuss the options with your doctor. For help locating the most appropriate facility to have your MRI or CT scan, you can use our cost comparison tools on myCIGNA.com or call the customer service number on the back of your CIGNA ID card.

Selecting Where to Go for a Colonoscopy, Endoscopy or Arthroscopy. When your doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using an independent outpatient surgery center for these procedures instead of a hospital can often save hundreds of dollars. Talk with your

Pre-certification

What is it?

1. It allows you to know in advance whether a procedure, treatment or service will be covered under your plan.
2. It helps ensure that you receive the appropriate level of care in the appropriate setting.
3. It enables CIGNA to identify situations that may allow you to receive additional attention (e.g., referrals to disease or case management programs) based on the type of service requested.

When do I need it?

This list does not include all services requiring pre-certification. These are only examples based on common procedures, treatments, and services.

- All inpatient admissions and non-obstetric observation stays, including those for:
  - Skilled nursing facilities
  - Rehabilitation facilities
  - Long-term acute care facilities
  - Hospice care
  - Transfers between in-patient facilities
- Potentially experimental and investigational procedures
- Potentially cosmetic procedures
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (cesarean section)
- Back surgery
- Certain outpatient procedures (see examples on following pages)
- Requests for in-network coverage of services from out-of-network health care professional *(if your plan only covers services from participating health care professionals).*

Questions?

Please visit myCIGNA.com or contact Customer Service at the toll-free number on your CIGNA ID card.

CIGNA®

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What outpatient services require pre-certification?

This list does not include all services requiring pre-certification. These are only examples based on common procedures, treatments and services.

- Please see your plan materials or check with your plan administrator for any exceptions.
- If you do not obtain pre-certification when required, your coverage may be reduced or denied.

PROCEDURE	DESCRIPTION	EXAMPLES
Potential Cosmetic or Reconstructive Procedures	■ Procedures that could potentially be categorized as cosmetic in nature. ■ Any procedure performed to improve appearance or self-esteem, and is not a covered service. Severe facial or physical deformities that may call for reconstructive surgery are intensely reviewed. ■ Pre-certification helps determine which procedures are medically necessary.	■ Breast reduction ■ Erectile dysfunction ■ Lipectomy ■ Skin removal or enhancement ■ Specific eye, ear or nose procedures ■ Treatment of varicose veins
Durable Medical Equipment (DME)	■ Non-disposable medical equipment that is appropriate for use in the home. Certain DME is reviewed for medical necessity.	■ Insulin pumps ■ Specialty wheelchairs ■ Seat/patient lift ■ Ultrasonic equipment ■ Speech generating devices
Home Health Care/ Home Infusion Therapy	■ Home health care – the use of nursing or other rehabilitative services provided in an individual's home. ■ Both services often indicate the need for other interventions.	■ Skilled nursing visits ■ Home health aides, private duty nurses, rehabilitation therapists or other ancillary health care professionals treating individuals in a variety of settings, including the person's home
Injectable Drugs	■ Injectable medications typically used to treat unique diseases and their consequences for a relatively small population. ■ Drugs are administered in the doctor's office or the home by a health care professional or the individual.	■ Medications used to treat conditions such as: –Infertility –Hemophilia –Multiple sclerosis –Rheumatoid arthritis ■ Some injectables such as growth hormone and immunoglobulins are reviewed for medical necessity

What services require pre-certification continued...

PROCEDURE	DESCRIPTION	EXAMPLES
MRIs/MRAs, CT Scans, and PET Scans	■ Advanced diagnostic imaging that shows detailed pictures of body organs and structures. ■ Pre-certification helps determine medical necessity and helps ensure that each individual receives the appropriate test.	■ CT/CAT Scans ■ PET Scans ■ MRIs/MRAs
External Prosthetic Appliances	■ Pre-certification allows for review of medical necessity/appropriateness.	■ Myoelectronic microprocessors
Biofeedback	■ This alternative therapy is a method of consciously controlling a body function that is normally regulated automatically by the body. ■ In many cases, scientific rationale for use is unclear, so therapy is reviewed on a case-by-case basis for medical necessity and effectiveness.	■ Control of conditions such as migraine and incontinence
Speech Therapy	■ A specific type of rehabilitation treatment prescribed when an individual has difficulty speaking. ■ Services require pre-certification to confirm coverage and help ensure appropriate care.	■ Speech therapy

Who obtains it?

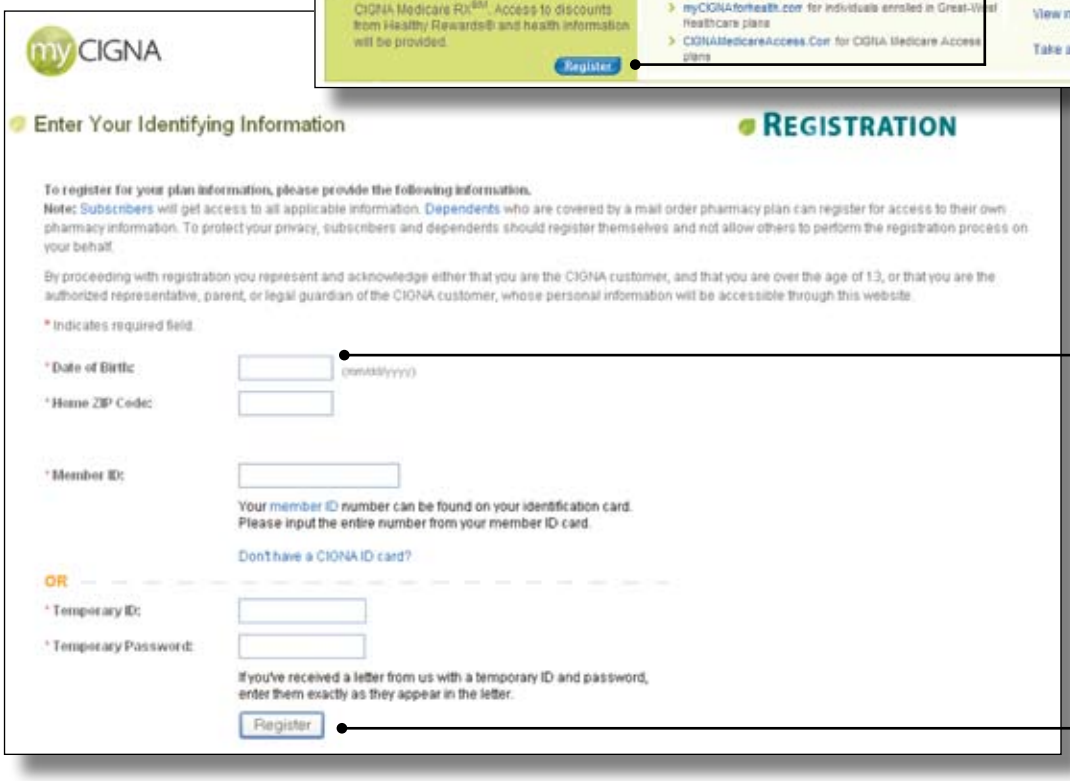
TYPE OF SERVICE	RESPONSIBILITY	NOTES
In-Network	Your Doctor	■ You may be required to pay a copay at the time of service. *(If you have a Health Reimbursement Account, the doctor sends a claim directly to CIGNA HealthCare.)* ■ Doctors have been credentialed by CIGNA HealthCare.
Out-of-Network *(if covered by your plan)*	You	■ To obtain pre-certification, call the toll-free number on your CIGNA ID card. ■ Your coverage may be reduced if you do not obtain pre-certification. ■ Your out-of-pocket costs will be higher.

Getting to know myCIGNA

Nothing is more important than your good health. That's why there's **www.myCIGNA.com** – your online home for assessment tools, plan management, medical updates and much more.

Step 1
Enter **www.myCIGNA.com** in the web address line on your browser.

Step 2
Click on the **Register** button.



Step 3
Enter your **Date of Birth, ZIP code** and your **Member ID number** which is printed on your ID card.

Step 4
Click on **Register**. Upon entering personal information a **Confirmation Page** should then appear. Click "**Accept**" if all information is accurate.

HIGHLIGHTS:

Visit myCIGNA – you can:

- Find personal plan and claim information.
- Print a temporary ID card or request a new one.
- Get health care information.
- Track total charges and what you pay out-of-pocket.
- Plan for health expenses.

That's not all. You can access quality and cost information for certain procedures, tests and surgeries to help you make more informed decisions about where to receive care.

Use this guide to help find important features to help you manage your health and make the most of your health plan.

Note: This guide is based on the experience of a typical user. Actual features may vary based on your plan and your individual security profile.

Getting to know myCIGNA

Home

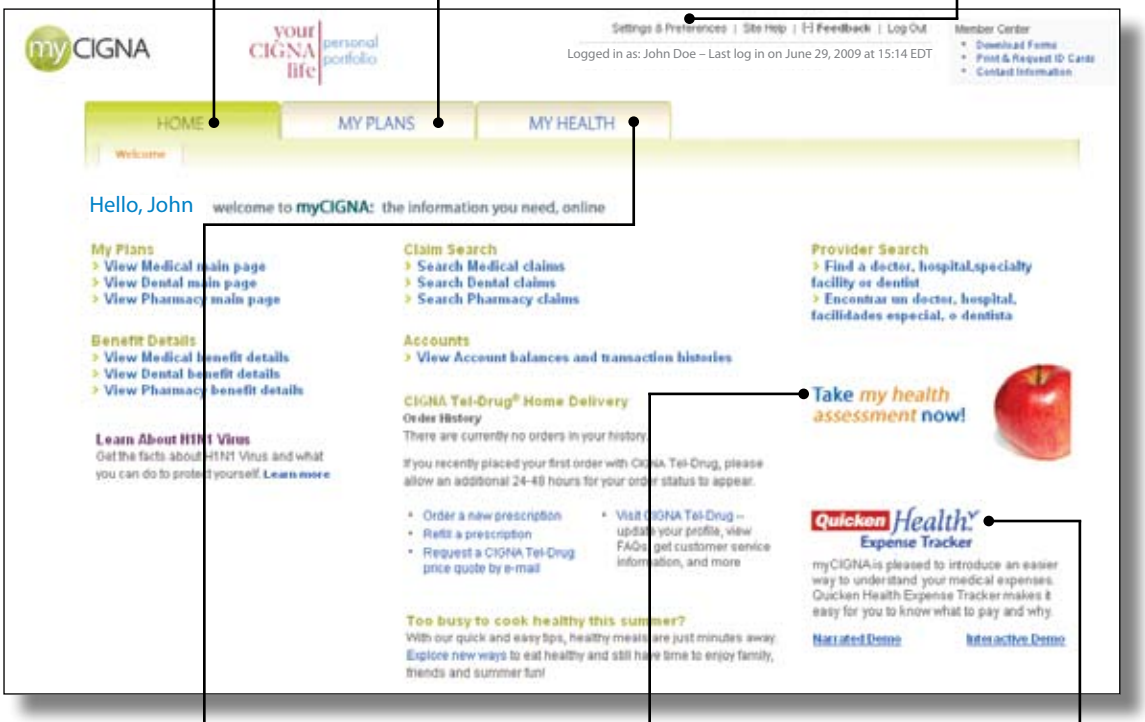
Upon log-in you'll land on your personal Welcome Page where you'll find quick links to the more popular online tools.

My Plans

Where most of your coverage details are found.

Settings & Preferences

Change your password, email address, default start page and preferences to things like email communication and your WebMD® health record.



My Health

Take advantage of a wealth of health-related resources including:

- Cost and quality comparisons
- WebMD tools
- Health management information
- Healthwise® Knowledgebase medical encyclopedia
- *my health assessment*

Health Assessment

Complete a confidential online questionnaire, and find personalized health and wellness recommendations.

Quicken Health Expense Tracker

An online tool that lets you organize, manage and monitor all your medical expenses and information in one place.

Getting to know

HIGHLIGHTS:

- Perform key tasks related to your medical plan.
- Search for claims, view plan information.
- Access your plan-specific directory.
- Access additional resources including commonly asked questions, health assessment, and preventive health information.

Note: This guide is based on the experience of a typical user. Actual features may vary based on your plan and your individual security profile.

Plan Summary
Find your plan information, including who's covered.

Medical Claims Quick Search
Search for claims for up to 365 days at a time. Claims are available for the past 24 months.

I Want to …
Search for a hospital, doctor, dentist, pharmacy, lab or clinic. Compare doctors and hospitals. Take *my health assessment* or print ID cards.

My Plans - Medical

Plan Summary
JOHN DOE
Plan: HRA/OPEN ACCESS PLUS
CIGNA Care Network
Pharmacy Plan: Tier 3
Account Number: 1234567
Effective Date: 07/30/2007
Status: Active
See who's covered

If you are enrolled in a HRA or HSA plan as a single individual with no dependents, your Medical Deductible and Out-of-Pocket information may be reflected in the Family sections on the myCIGNA.com My Medical Deductibles - Year-to-Date and Benefit Details Screen. If so, please disregard the "Does Not Apply" that is reflected in the Individual Deductible and Out-of-Pocket sections and refer to the Family sections for your Deductible Accumulations and benefit details.

Medical Claims Quick Search
Find medical claims for: JOHN DOE
Service date(s) within: Last 30 Days — Find Claims
› Advanced date range search

I Want to...
- Find a doctor, hospital or special facility
- Encontrar un doctor, hospital, o facilidades especial
- Estimate medical costs for a condition or procedure
- Take *my health assessment*
- Print a temporary ID card
- Request a new ID card
- Compare Hospitals
- Learn more about Well Informed

Message from CIGNA
Quest Diagnostics (1.800.377.7220) and Laboratory Corporation of America (1.888.522.2677) are preferred national laboratories. Ask your doctor, call or visit these links for locations nearest you.
View the Getting to Know myCIGNA Guide (PDF 1.9M) for more detailed information on myCIGNA.
Losing your health plan coverage? Choices for maintaining health coverage after a loss of employment or other triggering event.

Message from your employer
Concerned about a major health problem? **New covered benefit:** Get a confidential online second opinion from the MyConsult® experts at Cleveland Clinic. more
New! Access Your Healthy Life Personal Health Team more

My Medical Deductibles - Year-to-Date
Track how much you have paid towards your deductible and accumulated towards plan maximums.

Deductibles - Year-to-Date	In Network		Out-of-Network
	Amount	Met	Remaining
Plan Accumulation	$1,500.00	$1,500.00	$0.00

› View deductibles and maximums for all members

Medical Benefits
› View your medical benefit details
Take a look at who's covered and what your plan covers, including answers to questions about deductibles, benefit maximums, out-of-pocket maximums and medical authorizations.

Additional Resources
› View preventive health benefit information (PDF 144k)
See what preventive and wellness services are covered.
› Add or Switch a Primary Care Physician
Search our provider directory to add or switch the designated Primary Care Physician for you or your dependents.

Related Health Resources
- MyConsult® Online Second Opinion (covered benefit)
- Behavioral Health Tools and Plan Information
- CIGNA Companies' Summary Plan Description (SPD)
- Convenience Care Clinics
- CIGNA Tel-Drug Home Delivery
- Healthy Life Personal Health Team

Discounts from Healthy Rewards®
Save on health and wellness products and services.
Select a Program — GO

My Medical Deductibles
Track how much you pay toward your deductibles (the amount you pay) and accumulate toward plan maximums.

Medical Benefits
View a summary of your plan's coverage, including answers to questions about what you need to pay out-of-pocket.

Discounts from Healthy Rewards®
Learn how you can save on health and wellness products and services.

Getting to know

HIGHLIGHTS:

- Search for claims.
- View plan information.
- Review real time drug pricing information based on your pharmacy plan.
- Order medications through CIGNA Home Delivery Pharmacy℠.
- Locate nearby pharmacies.
- Compare your medication with other drug options, including brand names, available generics and other low-cost drug alternatives.
- Confidentially submit questions to a pharmacist for answers you need.

Note: This guide is based on the experience of a typical user. Actual features may vary based on your plan and your individual security profile.

Price a Medication

Compare costs of your prescription drugs at specific retail pharmacies and CIGNA Home Delivery Pharmacy.

I Want to …

Find links to popular tasks, such as searching for a pharmacy, downloading a form and printing ID cards.

My Plans - Pharmacy

Plan Summary
JOHN DOE

Plan: Tier 3
Account Number: 1234567
Effective Date: 07/30/2007
Status: Active

See who's covered

Message from CIGNA

Pay less when you fill your Lipitor prescription. Lipitor is now a Preferred Brand in the CIGNA Prescription Drug List. Visit the Prescription Drug Price Quote Tool and review real-time drug pricing information based on your pharmacy plan.

View the Getting to Know myCIGNA Guide (PDF 1.9M) for more detailed information on myCIGNA.

Getting your medication can be faster and easier when your doctor sends your prescriptions electronically. more

Ordering from CIGNA Tel-Drug? We are unable to process online orders for new prescriptions at this time. New prescriptions must be ordered by mail. Refill orders are not affected. more

We apologize for this temporary inconvenience. **Urgent need?** Contact your doctor for a 30-day prescription that can be filled at your local pharmacy.

See what others are saying about the Prescription Drug Price Quote tool, then scroll down to give it a try!

"This website is awesome! With the economy as it is, it is extremely helpful to know what costs you are facing, especially for maintenance drugs. The data regarding alternatives is also very helpful. Thank you for making access to important benefit information much easier."
"It was nice to review pharmacy on-line and help make better choices between generic and name brand drugs."
"This is a great tool to use especially during these economic times when you really have to watch every cent you spend."

Price a Medication
› Get a prescription drug price quote
Determine drug costs and find out if it's covered by your plan.

CIGNA Tel-Drug® Home Delivery Pharmacy
You could save more with the convenience of home delivery for medications you take on a daily basis.

- Request a new prescription from CIGNA Tel-Drug Home Delivery Pharmacy
- Refill a prescription from CIGNA Tel-Drug Home Delivery Pharmacy
- Check the status of your order
- Visit CIGNA Tel-Drug – update your profile, view FAQs, get customer service information and more

Pharmacy Claims Search
› Search claims for JOHN DOE
View pharmacy claim information. History is available for the past 16 months.

Pharmacy Benefit Details
› View your pharmacy benefit details
Take a look at who's covered and what your plan covers, including answers to questions about deductibles.

I Want to...

- Find a Pharmacy in CIGNA's Provider Directory
- Encontrar una farmacia en el Directorio de Proveedores de CIGNA
- Get a Prescription Drug Claim Form
- Download a Tel-Drug® Mail Order Form (PDF 342k)
- Request a new ID card
- Print a temporary ID card
- Learn more about Well Informed

Related Health Resources

- Top 50 Drugs and their Generic Equivalents
- A to Z encyclopedia of medications (Provided by Healthwise)
- Consumer's Guide to E-Prescribing. (PDF 465kb)

Discounts from Healthy Rewards®

- Save on health and wellness products and services.

Select a Program GO

CIGNA Home Delivery Pharmacy

Order a new prescription or refill an existing prescription through our convenient mail-order service. Take advantage of our lower costs and get a 90-day supply delivered to your door at no additional cost for delivery.

Pharmacy Claims Search

Search for pharmacy claims for the primary plan subscriber for the past 16 months.

HIGHLIGHTS:

- View balances and transaction history for accounts specific to your plan such as a Health Reimbursement Account (HRA), Health Savings Account (HSA), Healthy Awards Account® or Flexible Spending Account (FSA).
- Find a list of services and expenses covered by your account(s).
- Get detailed information on how your account(s) work.

Note: This guide is based on the experience of a typical user. Actual features may vary based on your plan and your individual security profile.

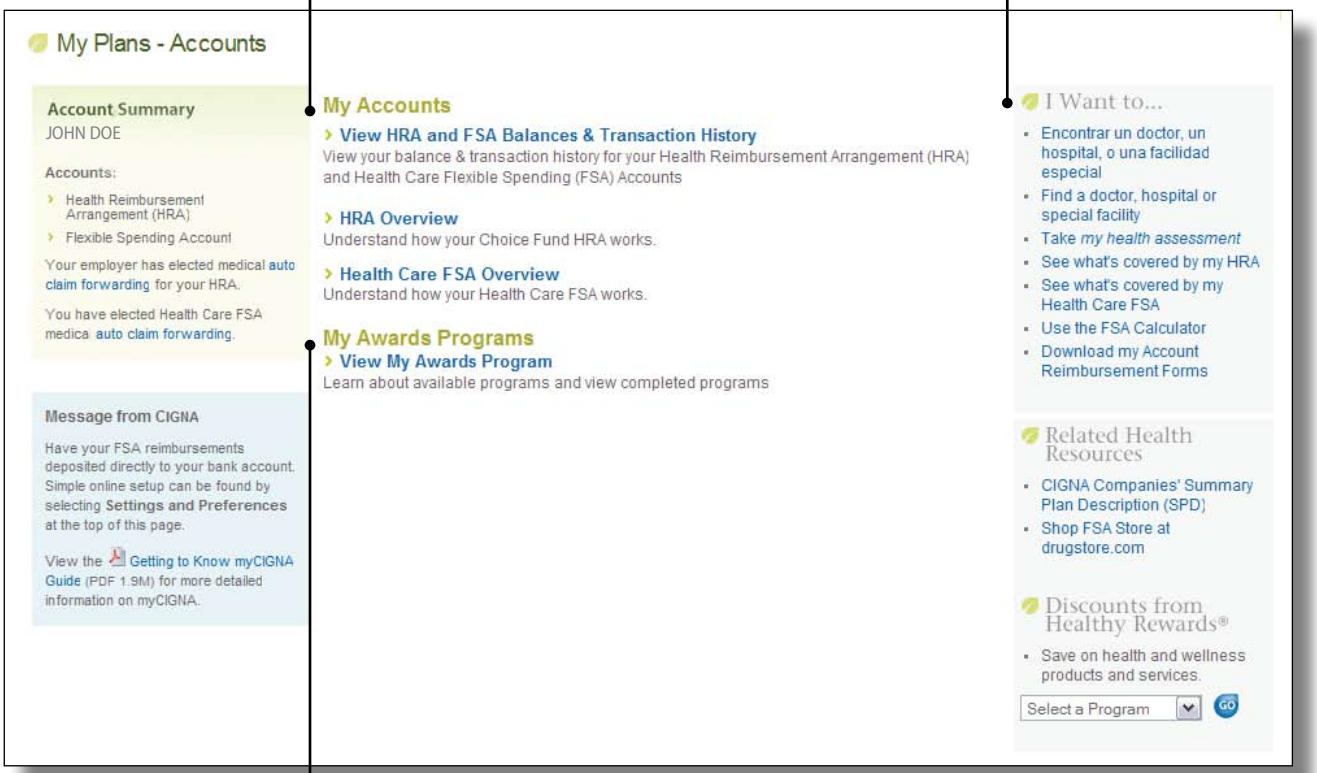
Getting to know myCIGNA

My Accounts

View your balances & transaction history for your account(s). Understand how your account(s) work.

I Want to …

Find links to popular tasks, such as searching for a doctor or hospital, learning what your account covers or downloading a form.



My Awards Programs

Learn about available programs and view completed programs.

Getting to know

HIGHLIGHTS:

Visit myCIGNA – you can:

- Complete *my health assessment*.
- Compare hospitals for cost and quality.
- Seek health advice.
- Learn more about a particular condition or procedure.
- Get estimated costs for specific procedures.
- Search the CIGNA 24-Hour Health Information Line℠ and Healthwise® Medical Encyclopedia for information on hundreds of medical topics.

Note: This guide is based on the experience of a typical user. Actual features may vary based on your plan and your individual security profile.

Cost and Quality Resources

Compare cost and quality between doctors and hospitals to help you decide where to receive care.

Health Management Resources

Find information on CIGNA HealthCare resources that help you get healthy and stay healthy. Depending on your plan, these resources include the CIGNA 24-Hour Health Information Line, CIGNA HealthCare Healthy Babies®, and CIGNA Health Advisor®.

My Health - Health Topics Overview

This Month's Health Topic

Hot weather? It's important to stay hydrated

Summer is here at last, and it's time to enjoy the sun as we play and exercise outdoors. When the weather heats up, it's important to be sure you drink enough fluids. Find out how much is enough, and what you should choose to drink, in the July "Your Health and Well-Being" newsletter (PDF 230k). You'll find tips for children at summer sports camps and games, too.

Summertime safety tips

Remember the simple basic precautions

- Apply sunscreen 30 minutes before you go outdoors.
- Use insect repellent with DEET to ward off mosquitoes and ticks. (Less than 10% DEET for children.)
- It takes 36 hours for a tick to transmit Lyme disease. Check yourself and your children for ticks before bedtime.
- Itchy bites? Topical anti-itch cream may help.

Message from CIGNA

Commitment to Quality (PDF 990kb)

View the Getting to Know myCIGNA

Cost and Quality Resources

- Hospital and other facility-based procedures & services
  Estimated cost range for specific procedures
- Hospital Comparison Tool
  Compare hospitals based on quality measures

More Cost and Quality Resources

Health Management Resources

- my health assessment
  Complete this questionnaire to identify your health risks and get personalized information on how to improve your health
- WebMD Personal Health Manager
  Personalized health tools and information such as WebMD Health Record and Symptom Checker
- Health Information Line
  Call the number on your ID card for 24-hour guidance on medical treatment, or listen for hundreds of the latest podcasts to help you stay informed about your health.
- Personal and Online Coaching Programs
  Covering a variety of health issues and topics, these programs provide either a trained advisor, who will work with you one-on-one, or online coaching and guidance

More Health Management Resources

Condition and Wellness Resources

Get help and information on these and other topics: search or browse the Healthwise® Medical Encyclopedia, an interactive library of more than 5,000 condition, health and wellness articles.

Arthritis
- Talk with your Personal Health Advisor
- Partner with a health coach to better

Men's Health
- Talk with your Personal Health Advisor
- Partner with a health coach to better

Medical Encyclopedia from Healthwise®

Find specific information on GO

Browse information by topic:
- Health Topics
- Medical Tests
- Medications
- Support Groups
- en Español

Focus on Prevention
- Covered Preventive and Wellness Services (PDF 450k)

Discounts from Healthy Rewards®
- Save on health and wellness products and services.

Select a Program GO

my health assessment

Help improve your health by completing this secure online health questionnaire.

Condition and Wellness Resources

Find support tools on a number of conditions. Learn how you can get healthy with our trained medical practitioners.

WebMD Personal Health Manager

A suite of tools and health resources to better assess, track and manage your personal health.

Medical Encyclopedia from Healthwise

Learn more about your condition, procedure or upcoming medical test. Find support groups or learn more about your medications.

Provider Directory

HIGHLIGHTS:

- Find all participating CIGNA HealthCare doctors, hospitals, pharmacies, labs and clinics.
- Get to know the different tools that can help you find quality care at lower costs. Find out how choosing a CIGNA Care designated specialist can save you on out-of-pocket costs.
- Select common conditions or procedures to find providers and experience a complete and uninterrupted scenario of care.

Note: This guide is based on the experience of a typical user. Actual features may vary based on your plan and your individual security profile.

Getting to know myCIGNA

Type of Provider

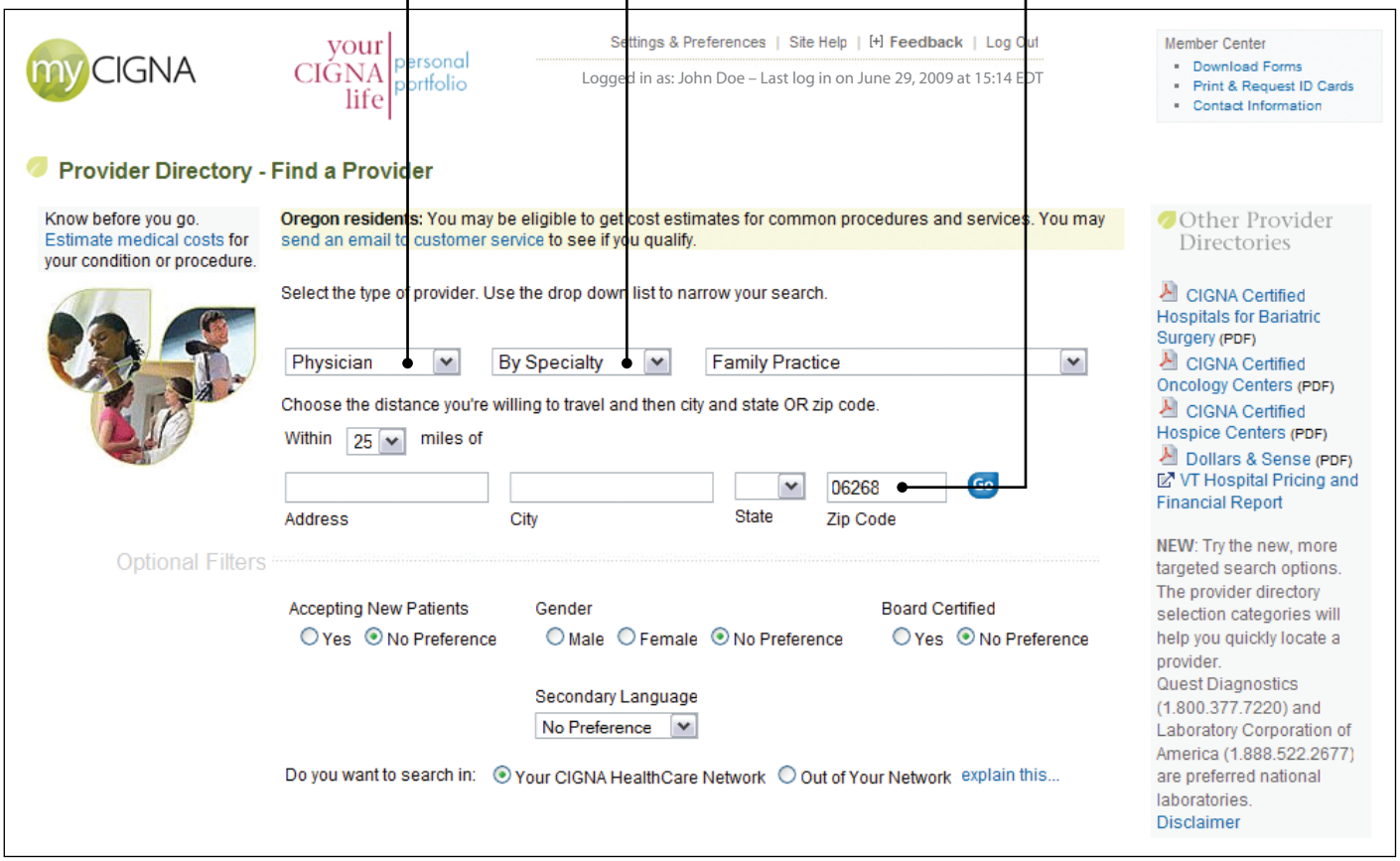
Find a doctor or hospital in your area. Look for a Center of Excellence, or if your plan includes CIGNA Care, consider a specialist with the CIGNA Care designation.

Search by Specialty

Look for a doctor or hospital based on a procedure, symptom or condition.

Search

Run your inquiry by City, State or ZIP. Specify how far you are willing to travel.



Guide to Your Explanation of Benefits

See how your benefits are working for you with this easy-to-understand document that shows you the costs associated with the medical care you've received.

When a claim is filed under your CIGNA benefits plan, you get an Explanation of Benefits (EOB). Because we know health care expenses can be confusing, we've simplified the language and summarized the most important information about the claim.

Page 1

The Summary page gives an overview of how your benefits are working for you – quickly see what was submitted, what's been paid, and what you owe.

Connecticut General Life Insurance Company
Bourbonnais Claim Office
PO Box 188003
Chattanooga, TN 37422-8033

CIGNA

Connecticut General Life Insurance Company

Customer service
Call the number on the back of your ID card or
1.800.244.6224 (1.800.CIGNA24)
www.myCIGNA.com
If you have any questions about this document please call Customer Service at the number above. Please have your reference number ready.

YOUR NAME
1 MAIN STREET
ANYWHERE, USA 12345

Service Dates
March 10, 2010

THIS IS NOT A BILL.
Your health care professional may bill you directly for any amount that you owe.

Reference # / ID
9999999999999 / U9999999999

Account name / Account #
ABC Company / 99999999

Explanation of benefits

for a claim received for YOUR NAME, Reference # 999999999999

Summary of a claim for services on March 10, 2010
for services provided by DR. JOHN WELLBEING

Amount billed	$230.00	This was the amount that was billed for your visit on 03/10/2010.
Discount	$41.35	You saved $41.35. CIGNA negotiates discounts with health care professionals and facilities to help you save money.
What my CIGNA plan paid	$188.65	CIGNA paid $188.65 to JOHN WELLBEING MD on 04/02/2010.
What my accounts paid	$0.00	$0.00 was paid from your Health Reimbursement Account (HRA), you now have $0.00 left. $0.00 was paid from your Flexible Spending Account (FSA), you now have $918.57 left.
What I owe	**$0.00**	This is the amount you owe after your discount, what your CIGNA plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid when you received care may reduce the amount you owe.
You saved	100%	You saved $230.00 (or 100%) off the total amount billed. This is a total of your discount and what your CIGNA plan paid. To maximize your savings, visit www.myCIGNA.com or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.

PLEASE SEE CLAIM DETAILS ON PAGE 3.

Date of service and health care professional are both listed for easier reference.

If your health accounts paid part of your expenses, you'll see what's been paid and remaining balances.

The amount you owe does not reflect any amount you may have already paid.

This reflects the total value of your plan – the amount you saved by visiting an in-network health care professional or facility, and the amount paid by your plan.

CIGNA

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Page 2

If you're unsure of words or terms, look them up under the Glossary.

Your Rights of Review and Appeal will help you figure out what to do if you disagree with any of the benefits decisions made on this claim.

Glossary

Amount billed: The amount charged by the health care professional or facility (physician, hosp
covered dependents.

Amount not covered: The portion of the amount billed that was not covered or eligible for pa
charges for services or products that are not covered by your plan, duplicate claims that are no
submitted that are above the maximum amount your plan pays for out-of-network care.

Deductible: The portion of submitted charges applied towards your deductible. Your deductib

Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the

If you're not satisfied with this decision, you can start the Appeal process by sending a written r
your plan materials within 180 days of receipt of this explanation of benefits (unless a longer tin
Please follow the steps below to make sure that your appeal is processed in a timely manner.

- If you're not satisfied with this coverage decision, you can start the Appeal process by submit

Page 3

The Claims Detail page follows the Glossary page. Here, you'll find:

The dollar amount and percentage CIGNA paid toward the covered amount, minus any copay/deductible you're responsible for.

The portion of covered expenses you're responsible for paying. For example, if your CIGNA plan covers 90% of the covered amount, you pay the remaining 10%.

CIGNA

Claim received for Your Name
Reference # 99999999999
ID 99999999999

THIS IS NOT A BILL.

Claim detail

CIGNA received this claim on March 26, 2010 and finished processing it on March 27, 2010.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/ Deductible	What my CIGNA plan paid	% paid	Coinsurance	My account paid	Account paid from	What I owe	See notes
Dr. John Wellbeing Reference 999999999999													
3/10/2010	PHYSICIAN	230.00	41.35	0.00	188.65	0.00	188.65		0.00	0.00		0.00	A
Total		**$230.00**	**$41.35**	**0.00**	**$188.65**	**0.00**	**$188.65**			**0.00**		**0.00**	

**After you have met your deductible, the cost of the covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.*

If your "Covered amount" is less than your "Amount billed," it could be due to CIGNA discounts (a portion you don't have to pay) or amounts not covered (a portion you might have to pay). The Notes section will tell you specific details.

What you have left in your plan deductibles and out-of-pocket expenses.

What I need to know for my next claim

You've now paid a total of $0 toward your $1,000 in-network deductible for this plan year.
You've now paid a total of $0 toward your $1,500 out-of-network deductible for this plan year.
You've now paid a total of $0 toward your $4,000 in-network out-of-pocket expenses for this plan year.
You've now paid a total of $0 toward your $5,500 out-of-network out-of-pocket expenses for this plan year.

Help with making an appeal if you're unsatisfied with part or all of your claim being denied. The information is state-specific.

Other important information that I need to know

Part 919 of the Rules of the Illinois Division of Insurance requires that our company advise you that if you wish to take this matter up with the Illinois Division of Insurance, it maintains an Office of Consumer Health Insurance (OCHI) in Chicago at 100 W. Randolph Street, Suite 9-301, Chicago, Illinois, 60601-3395 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767-0001. The OCHI can also be reached toll free within Illinois at 877.527.9431. The main telephone number for the Chicago office is 312.814.2420 and for the Springfield office is 217.782.4515.

Notes

A. Thank you for using the CIGNA HealthCare preferred provider organization (PPO) network. This represents your savings, so you are not required to pay for this amount. This provider is prohibited from billing the patient for the difference. If you have already paid the amount in full, please request reimbursement from your provider. IN. or CA. health care professionals, for information regarding the contractual source of your discounted rate, please contact CIGNA customer service at 1.800.88cigna (882.4462)

RETAIN THIS FOR YOUR RECORDS

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CIGNA

CIGNA LIFESOURCE Transplant Network®

As a CIGNA HealthCare member, you'll have access to the CIGNA LIFESOURCE Transplant Network®, a network of participating organ and tissue transplant centers. Developed by a team of CIGNA HealthCare clinical professionals, the Transplant Network includes respected hospitals and medical centers throughout the country.

Each transplant facility is evaluated for favorable rates of patient outcomes, support services and ''patient friendly'' environments, before it is included in the CIGNA LIFESOURCE Transplant Network.

CIGNA LIFESOURCE participants are managed by the Comprehensive Transplant Case Management Unit. This unit consists of Registered Nurses with clinical experience in transplant, hematology/oncology, home health care, dialysis, critical care and/or community care. They are specially trained to manage complex transplant cases.

Benefits from the Comprehensive Transplant Case Management Unit include:

- Clinical partnership with providers
- Consistency in service and benefit administration
- Dedicated resources for complex areas of medicine
- Advocacy
- Administrative efficiency

In some instances a travel reimbursement is offered as a feature of the program. Please be aware that most of these expenses are considered taxable income.

As a CIGNA HealthCare member, you can have access to these services when they are coordinated through your physician and your CIGNA HealthCare plan Medical Director.

Respected hospitals and medical centers throughout the United States.

You may not receive the in-network level of benefits for all types of transplants at all facilities. In addition, our network of facilities changes frequently. For the most current listings with the programs covered at the in-network benefit level, please visit *www.cigna.com/lifesource* or call CIGNA LIFESOURCE Member Services at 800.668.9682.

Not all CIGNA LIFESOURCE Transplant Network facilities are available to members in all plans. Please call Member Services at 800.668.9682 for more information. If you are already in transplant case management, please call your case manager directly.

Spend less on prescription medications

As consumers, we often price shop to get the best value for our dollar. But you may not realize that you can also compare prices for prescription medications. There are often many medications that treat a particular illness. The medications may be equally effective, but their costs can vary greatly. Here are some tips on how to save money on prescription medications by choosing medications that offer better health value and cost less.

Know Your Pharmacy Benefit

Each prescription medication has a copay, which is the amount that you pay for that medication under your pharmacy benefit. The copay amount depends on which "tier" the medication is in on your Prescription Drug List (PDL). Medications in Tier 1 have the lowest copay, and they are your most affordable options. Medications in Tier 3 have the highest copay. Knowing which medications are in Tier 1 and Tier 2 will help you understand where you can save money.

- Go to **myCIGNA.com** after January 1, 2011 or **www.CIGNA.com** and click on "Drug Lists" to price medications and make note of your lowest cost options. Ask your doctor if they are appropriate for your treatment.
- Ask your doctor or pharmacist if a less expensive alternative is available.
- Call the customer service number on your ID card and ask the representative to check for lower cost options.

Consider Pharmacies That Offer Discounts on Generics

Some retail pharmacies offer very low prices on select generic drugs—often less than your usual copay—and include commonly prescribed generic medications for several conditions such as asthma, anxiety, high blood pressure and infection (antibiotics).

- Ask your doctor if there is a generic alternative that is appropriate for your treatment.
- Refer to the list on the back to see generic medications that are often included in retail generic discount programs.
- Check with your local pharmacy to see if it offers a discount on generic medications.
- Be sure to give the pharmacist your ID card so the claim can be processed under your pharmacy benefit. You should only have to pay the pharmacy's discounted cost.

Ask About Over-the-Counter (OTC) Alternatives

Several popular brand-name medications have been approved for OTC sales in recent years. Prescription strength formulas are available without a prescription for conditions such as allergies, heartburn and acid reflux.

- Ask your doctor or pharmacist if there is an OTC alternative available that is right for you.
- Use your Flexible Spending Account dollars on eligible products.
- Check product and manufacturer Web sites for money saving coupons.

To obtain a list of medications included in discount programs you can log on to the following local pharmacies:

Walmart
http://www.walmart.com/catalog/catalog.gsp?cat=546834

Target Pharmacy
http://sites.target.com/site/en/health/generic_drugs.jsp?sort

Walgreens
https://webapp.walgreens.com/MYWCARDWeb/servlet/walgreens.wcard.proxy.WCardInternetProxy/RxSavingsRH?

CVSPharmacy
http://www.cvs.com/CVSApp/images/promotions/landingpages/rx/rx08037_health_sav_pass/health_savings_pass_medicationlist.pdf

Publix
http://www.publix.com/wellness/pharmacy/GenericDrugInformation.do

Declination of Healthcare Coverage Affidavit

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided through Miami-Dade County Public Schools (M-DCPS).
2. The benefits of the plans have been thoroughly explained to me, and I decline to participate.
3. I have other medical coverage currently in effect (not a School Board-sponsored plan).
4. I understand that if I desire to apply for medical insurance at a later date, I may enroll only during an annual enrollment period determined by M-DCPS or during a "special enrollment period" (Change in Status) following an IRS acceptable change in status event. For example, you may in the future be able to enroll yourself or your dependents in a group medical plan through the School Board if you or your dependents lose coverage under an existing employer provided medical plan, provided that you request enrollment within 30 days after your other group product coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption (or placement for adoption), you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the event. In case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for cause or as a result of failure to pay any contributions toward the cost of coverage on a timely basis.
   NOTE: Internal Revenue Service (IRS) guidelines state that the loss of insurance through an **individual** Healthcare **plan does not** constitute a valid Change in Status event.
5. I understand that I will not be enrolled in a Board-Paid medical plan. I will receive Board-Paid Standard Short-Term Disability and will receive $100 per month paid through the payroll system. (This may be subject to withholdings and FICA.)
6. I understand that I must provide proof of other group healthcare coverage. Otherwise, I understand that I will be auto-assigned CIGNA OAP 20 (employee only) coverage.

I have read, understand and agree to comply with the requirements stated above.

_____	_____
Print Name	Employee Number
_____	_____
Signature	Date

Attached is my proof of group healthcare coverage.

NOTE: Please fax this affidavit and proof of other group healthcare coverage to 305-995-1425.

Florida KidCare

What is Florida KidCare?

Your child may be eligible for health insurance through Florida KidCare even if one or both parents are working. Getting health insurance for your children before they get sick is very important. Through Florida KidCare, the state of Florida offers health insurance for children from birth through age 18. It includes four different parts. When you apply for the insurance, Florida KidCare will check which part your child may qualify for based on age and family income.

What services are covered:

Florida KidCARE covers everything from transplants and everything else in-between. Here are some of the services Florida KidKare covers: Doctor Visits, Shots, Surgery, Vision, Check-ups, Prescriptions, Emergencies, Hospital, and Hearing.

Eligibility Requirements

Florida KidCare is for children, not adults. To qualify for premium assistance, a child must:

- Be Age 5 - 18
- Be uninsured
- Meet income eligibility requirements
- Be a U.S. citizen or qualified non-citizen
- Not be eligible for Medicaid or Children's Medical Services Network
- Not be the dependent of a state employee eligible for health insurance
- Not be in a public institution.

Why all the fuss about health insurance?

Children with health insurance are more likely to:

- Get the help they need when sick or hurt.
- Get the shots they need.
- Miss fewer days of school.
- See their own doctor and nurse who know them.

Children need to have regular check-ups to make sure they are growing strong and healthy. Healthy children do their best at school and play.

Costs

There is no charge for Medicaid for children (KidCare Medicaid). For other Florida KidCare programs, monthly premiums depend on your household's size and income. Most families pay $15 or $20 a month. If you need to pay more, Florida KidCare will let you know. You may have to pay small charges or co-payments for some serves. A child who is a member of a federally recognized American Indian or Alaskan Native tribe may qualify for no-cost Florida KidCare.

Healthplans

AMERICGROUP Florida, Inc:	1-800-600-4441
Simply HealthCare Plans:	1-800-887-6888
Staywell Health Plan:	1-866-698-5437
UnitedHealthcare of Florida, Inc.:	1-888-216-0015
Vista Health Plan:	1-866-847-8235

Dental Plans

DentaQuest, Inc., (A DentaQuest Company):	1-800-964-7811
MCNA Dental Plans	1-800-494-6262

2011 Federal Poverty Annual Guidelines

Family size #	100%	130%	185%	200%
1	$10,890	$14,157	$20,147	$21,780
2	$14,710	$19,123	$27,214	$29,420
3	$18,530	$24,089	$34,281	$37,060
4	$22,350	$29,055	$41,348	$44,699
5	$26,170	$34,021	$48,415	$52,340
6	$29,990	$38,987	$55,482	$59,980
7	$33,810	$43,953	$62,549	$67,619
8	$37,630	$48,919	$69,616	$75,260
For each add'l #	$3,820	$4,966	$7,067	$7,640

Families who are not eligible for premium assistance may buy Florida KidCare at the "full pay" premium rate.

KidCare Costs

Reduced: $15 or $20 per family per month based on family size and monthly income.

Non-reduced: $121.00 per child without dental

Non-reduced: $131.00/child with dental

Florida Healthy Kids Benefits	Co-Pay Amount
Office visits for Minor Illness, Accident Care (Primary Care Provider)	$5 Co-Pay
Well Child Care	No Co-Pay
Routine Vision and Hearing Screening	No Co-Pay
Specialist Office Visit (Referred)	$5 Co-Pay
Behavioral Health Services (Pre-authorized, Outpatient - 40 visits per year, Inpatient/Residential - 30 days per year #	$5 Co-Pay
Substance Abuse Rehabilitation and Treatment (Pre-authorized,- 40 outpatient visits, 7 inpatient days for detox, 30 residential days)	No Co-Pay
Diagnostic Testing (Laboratory, X-rays, etc.)	No Co-Pay
Emergency Services	$10 Co-Pay
Emergency Ambulance Services	$10 Co-Pay
Hospital Inpatient Medical and Surgical Care (Pre-Authorized,includes 15 day rehabilitation stay for non-acute confinement)	No Co-Pay Semi-Private
Surgeon Fees (Pre-Authorized)	No Co-Pay
Maternity Services and Delivery	No Co-Pay
Anesthesia Services	No Co-Pay
Organ Transplants (Non-experimental, when authorized by Insurer at Insurer approved facility)	No Co-Pay
Pharmacy (Medicaid formulary, Generic)	$5 Co-Pay
Durable Medical Equipment and Prosthetic Devices (Pre-Authorized)	No Co-Pay
Refractions/Corrective Lenses (After failing vision screening - 1 pair every 2 years or when head size or prescription changes warrant)	$10 Co-Pay
Hearing Aids	No Co-Pay
Outpatient PT, OT and Speech Therapy (Up to 24 sessions within 60 day period)	$5 Co-Pay
Home Health Services (Skilled Nursing Only)	$5 Co-Pay
Hospice Services	$5 Co-Pay
Skilled Nursing Facility (Pre-Authorized, 100 days per year #)	No Co-Pay

Getting Answers

Getting answers to many of your FSA questions is now easier than ever. The FBMC Customer Care Centeroffers you a variety of resources to make inquiries on your benefits and Flexible Spending Accounts (FSAs), including information from the FBMC Web site, Interactive Voice Response system or Customer Care.

FBMC Web Site

FBMC's Web site provides information regarding your benefits and comprehensive details on your FSAs.

By entering **www.myFBMC.com** into your Internet browser, you will open FBMC's home page. Answers to many of your benefit questions can be obtained by using the navigational tabs located along the top portion of the home page. You'll be prompted to enter your Social Security number (SSN) and Personal Identification Number (PIN), last four digits of your SSN. After this login, you can access the following benefit information.

Benefits

You may check your benefit status, read benefit descriptions, access our tax calculator and much more.

Claims

Not only can you check the status of your claim, but you may also download forms, get more information about mailing and faxing your claim to FBMC or see transactions that need documentation.

Accounts

View your account balance and contributions. You may also view monthly statements and review your transaction history.

myFBMC Card® Visa® Card

You may download a card fact sheet or transmittal form, read the detailed instructions on proper use and open our drugstore listings to maximize card convenience.

Profile

Change your e-mail address or your mailing address, complete your online registration or select a new PIN.

Resources

Peruse our extensive resource library, including benefit materials, surveys, Over-the-Counter drug listings and benefit tips.

Forms

Download applicable forms for claim submission and reimbursement.

FBMC Interactive Benefits

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)

To access both the FBMC Web site and the Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN, whether using the Web site or the IVR system. After your initial login, you will be asked to register and select your own confidential PIN to access both systems in the future. Your PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero.

Record PIN here.
Remember, this will be your PIN for both FBMC Web and IVR access.

If you forget your PIN, click the "Need Help?" link on the Web site for help or you may call Customer Care at 1-800-342-8017.

NOTE: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.

NOTE: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax Toll-Free to: 1-888-800-5217

Reimbursement Methods for Medical FSAs:

- Your check will be mailed to your home.
- You may have your reimbursement direct deposited into your bank account.
- You may also use your new myFBMC Card® Visa® Card a stored value card – to receive instant reimbursements with no out-of-pocket expense.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account.
- There is no fee for this service.
- With Direct Deposit, you don't have to wait for postal service delivery of your reimbursement.
- You will receive notification by mail that your claim has been processed.

To apply, visit **www.myFBMC.com** or call the FBMC Customer Care Center at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four to six weeks.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact FBMC Customer Care.

- Visit **www.myFBMC.com**
- Call **1-800-342-8017**
  (Monday-Friday, 7 a.m. - 10 p.m. ET).

Please note that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

Receiving Reimbursement

NEW ONLINE CLAIMS SUBMISSION:

FBMC is pleased to announce online FSA claims submission through **www.myFBMC.com**. This process allows you the opportunity to submit, via the Web, a scanned image of your completed claim form along with scans of supporting documentation.

Submitting claims online gets reimbursement requests to FBMC faster than traditional mail, thus expediting the release of your reimbursement funds. Further details and instructions are available on the Web. Log in to your account for more information.

If you have questions regarding online claims submission, contact the FBMC Customer Care Center at 1-800-342-8017 (Monday - Friday 7 a.m. - 10 p.m. ET).

OR RECEIVE REIMBURSEMENT BY MAIL:

Your reimbursement will be processed within 15-20 business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Form. Download the Reimbursement Request Form online at **www.myfbmc.com.** To avoid delays, follow the instructions for submitting your reimbursement requests included in the FSA materials packet you will receive following enrollment.

Flexible Spending Accounts (FSAs)

What is a Flexible Spending Account?

Fringe Benefits Management Company (FBMC) provides you with IRS tax-favored Flexible Spending Accounts (FSAs) to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax-free
- per-pay-period deposits from your pre-tax salary
- savings on income and Social Security taxes and
- the security of paying anticipated expenses with your FSA.

Is an FSA right for me?

If you spend $200 or more on recurring eligible medical expenses during your plan year or $250 on eligible dependent care expenses, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis **by visiting the "Tax Calculators" link at www.myFBMC.com**.

What types of FSAs are available?

Your employer offers you a Medical Expense FSA as well as a Dependent Care FSA. If you incur both types of expenses during your plan year, you can establish both types of FSAs.

Medical Expense FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Medical Expense FSA, including:

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-Counter items.

Dependent Care FSAs

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- day care services
- in-home care
- nursery and preschool
- summer day camps.

Refer to the *Medical Expense FSA and Dependent Care FSA* sections of the online Open Enrollment Guide for specifics on each type of FSA.

How do I request reimbursement?

For Medical Expense FSA:

Requesting reimbursement from your Medical Expense FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form, which you may download at **www.myfbmc.com**, along with the following:

- a receipt, invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost and
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the receipt, invoice or bill for the service.

For Dependent Care FSA:

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with receipts showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

FSA Savings Example*

With an FSA		Without an FSA
$31,000	Annual Gross Income	$31,000
- 5,000	FSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,889	Federal, Social Security Taxes	-7,021
$20,111	Annual Net Income	$23,979
- 0	Cost of Recurring Expenses	-5,000
$20,111	Spendable Income	$18,979

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

$1,132!

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calender year

Medical Expense FSA

Minimum Annual Deposit: $200

Maximum Annual Deposit: $5,000

NOTE: Employees hired mid-year must calculate minimum/maximum amounts based on remaining payroll deductions.

What is a Medical Expense FSA?

A Medical Expense FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

Your Medical Expense FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse and
- your qualifying child or qualifying relative

An individual is a **qualifying child** if the child is not someone else's qualifying child and:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- has a specified family-type relationship to you
- lives in your household for more than half of the taxable year
- is 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- has not provided more than one-half of their own support during the taxable year.

An individual is a **qualifying relative** if the relative is a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- has a specified family-type relationship to you, is not someone else's qualifying child and receives more than one-half of their support from you during the taxable year **or**
- if no specified family-type relationship to you exists, is a member of and lives in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

NOTE: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self care. An eligible child of divorced parents is treated as a dependent of both, so either parent or both parents can establish a Medical Expense FSA.

Visit www.myFBMC.com for a list of frequently asked questions.
You must keep your documentation for a minimum of one year and submit to FBMC upon request.

Can travel expenses for medical care be reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Medical Expense FSA. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- parking fees
- tolls and
- transportation to another city.

When are my funds available?

Once you sign up for a Medical Expense FSA and contributions commence, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

Partial List of Eligible Medical Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
Injections and vaccinations
In vitro fertilization
Nursing services
Optometrist fees
Orthodontic treatment
OTC Medicines & drugs (with order, directive or prescription from your attending physician)
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

NOTE: Budget conservatively. No reimbursement or refund of Medical Expense FSA funds is available for services that do not occur within your plan year, or grace period.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Medical Expense FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires that the complete name of all medicines and drugs be obtained and documented on pharmacy receipts. This information must be included when submitting your request to FBMC for reimbursement.

Over-the-Counter Expenses

Your Over-the-Counter (OTC) medicines and drugs may be reimbursable through your Medical Expense FSA. Save valuable tax dollars on certain categories of OTC medicines and drugs, such as: allergy treatments, antacids, cold remedies and pain relievers. For a more comprehensive list of eligible OTC items, please visit **www.myFBMC.com**.

You may be reimbursed for OTCs through your Medical Expense FSA if:

- the medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the medicine or drug
- the reimbursement request is for an expense allowed by your employer's Medical Expense FSA plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner already described in your benefits enrollment information.

NOTE: OTC medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at **www.myFBMC.com**. As soon as an OTC item, medicine or drug becomes eligible, it will be reimbursable retroactively to the start of the then current plan year.

Newly eligible OTC medicines and drugs are not considered a valid change in status event that would allow you to change your annual Medical Expense FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

The Patient Protection and Affordable Care Act (PPACA) Healthcare Reform, approved by congress and signed into law by President Obama changes the way some Over-the-Counter (OTC) items qualify for Flexible Spending Account (FSA) reimbursement. Beginning January 1, 2011, certain OTC drugs and medicines will no longer be eligible for reimbursement without an order, directive or prescription from your attending provider. FBMC will continue to provide updates and post an updated OTC category list on this site as information becomes available. It's important to remember that you can still use your FSA funds for other eligible medical expenses and prescription purchases at pharmacies. Unaffected OTC items will still be reimburseable, as well as affected OTC items with a doctor's prescription or Letter of Medical Need. Please visit www.myFBMC.com for more information. If you have any questions regarding this new legislation, please contact FBMC Customer Care.

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable if the proper documentation is attached to the initial FSA Reimbursement Request Form each plan year:

- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service incurred, the name of the eligible individual receiving the service and the cost for the service
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call the FBMC Customer Care Center at 1-800-342-8017.

Should I claim my expenses on IRS Form 1040?

With a Medical Expense FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax free, regardless of the amount. By enrolling in a Medical Expense FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on the percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Medical Expense FSA include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

When do I request reimbursement?

You may use your Medical Expense FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

FSA WORKSHEET
Tax-Free Medical Expense FSA

Projected Expenses Plan Year 2011

1. **Uninsured Eligible Medical Expenses**

Medical deductible, co-insurance	_____
Medical & prescription co-payments	_____
Dental deductible, co-insurance or co-payments	_____
Immunizations, injections & vaccinations	_____
Routine exams and physicals	_____
Orthodontic expenses*	_____
Vision exams	_____
Eyeglasses & contacts (corrective)	_____
Hearing exams	_____
Other expenses	_____

2. **Total uninsured eligible expenses**, January 1, 2011, through December 31, 2011. Amount cannot exceed $5,000. _____

3. **Divide** by number of payroll deductions in plan year. This is the amount taken from each paycheck and deposited into your Medical Expense FSA. _____

* Medical expenses incurred for primarily cosmetic reasons, including orthodontic procedures, are not eligible for reimbursement.

Minimum annual amount: $200. Maximum: $5,000 contribution.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit. Visit www.myFBMC.com to download this form or call the FBMC Customer Care Center at 1-800-342-8017.

FSA WORKSHEET
Tax-Free Dependent Care FSA

Estimate your eligible dependent care expenses from January 1 through December 31, 2011.

1. **Multiply** your weekly day care expenses by the number of weeks you expect to have the expenses January 1, 2011, through December 31, 2011. _____

2. **Divide** by the number of payroll deductions in the plan year. This is the amount taken from each paycheck and deposited into your Dependent Care FSA. Amount cannot exceed your maximum tax filing status. See Page 61 for details. _____

Minimum annual amount: $250. Maximum: $5,000 contribution. (maximum amount based on your tax filing status)

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit. Visit www.myFBMC.com to download this form or call the FBMC Customer Care Center at 1-800-342-8017.

Dependent Care FSA

Minimum Annual Deposit: $250

Maximum Annual Deposit: The maximum contribution depends on your tax filing status as the list on this page indicates†.

What is a Dependent Care FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent care expenses for qualifying individuals.

A qualifying individual includes a **qualifying child**, if the child:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- has a specified family-type relationship to you
- lives in your household for more than half of the taxable year
- is 12 years old or younger and
- has not provided more than one-half of their own support during the taxable year.

A qualifying individual includes your **spouse**, if the spouse is:

- is physically and/or mentally incapable of self care
- lives in your household for more than half of the taxable year and
- spend at least eight hours per day in your home.

A qualifying individual includes your **qualifying relative**, if the relative:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- is physically and/or mentally incapable of self care
- is not someone else's qualifying child
- lives in your household for more than half of the taxable year
- spend at least eight hours per day in your home and
- receive more than one-half of their support from you during the taxable year.

NOTE: Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

Partial List of Eligible Dependent Care Expenses*

After school care
Baby-sitting fees
Daycare services
Elder Care Services
Deposits
In-home care/au pair services
Nursery and preschool
Registrations
Summer day camps

NOTE: Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

What is my maximum annual deposit?†

- If you are married and filing separately, your maximum annual deposit is $2,500.
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care FSA is always tax-free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information. You may also visit **www.myFBMC.com** to complete a Tax Savings Analysis.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care FSA include:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

When do I request reimbursement?

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

If I experience a Change in Status, can I start, stop or change the level of contribution to my Dependent Care FSA?

In determining your annual contribution during the enrollment period, consider any time that you will not incur eligible expenses during the plan year (i.e., vacation, child starting kindergarten, etc.), as some events do not constitute a permitted mid-plan year election change and changes to your contribution amount will not be allowed.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with receipts showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax Toll-Free to: 1-888-800-5217

NOTE: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Medical Expense FSA or vice versa.
3. You have a three month and 15 day run-out period (until April 15) at the end of the plan year for reimbursement of eligible Medical Expense FSA expenses incurred during your period of coverage and any applicable grace period within the Plan Year.
4. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service which you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the 2011 Plan Year. IRS regulations state that any unused funds which remain in your FSA after the run-out period ends and all reimbursable requests have been submitted and processed cannot be returned to you nor carried forward to the next plan year. Use the FSA Calculation Worksheet on Page 60 to determine your annual contribution estimate.
8. When enrolling in either or both FSAs, written notice of agreement with the following will be required.
   - I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents
   - I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
   - I will not seek reimbursement through any additional source and
   - I will collect and maintain sufficient documentation to validate the foregoing.
   - I agree to a salary deduction for the amount of any outstanding myFBMC Card® transactions (as permitted by law) if I do not send in documentation for an unverified myFBMC Card® expense. See Page 64 for details on the card.

What documentation of expenses do I need to keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To obtain forms after enrolling in either a Medical Expense or Dependent Care FSA, such as an FSA Reimbursement Request Form, Letter of Medical Need or Direct Deposit Form, visit FBMC's Web site, **www.myFBMC.com** or call the FBMC Customer Care Center at 1-800-342-8017.

Will contributions affect my income taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

FSA Grace Period

IRS Revenue Notice permits a "**grace period**" of two months and 15 days following the end of your 2011 Plan Year (December 31, 2011) for a Medical Expense FSA. This grace period ends on March 15, 2012. **During the grace period, you may incur expenses and submit claims for these expenses.** Funds will be automatically deducted from any remaining dollars in your 2011 Medical Expense FSA.

You should not confuse the grace period with the plan's "**run-out period**." The run-out period extends until April 15, 2012. This is a period for filing claims incurred anytime during the 2011 Plan Year, as well as claims incurred during the grace period mentioned above.

Your Dependent Care FSA also has a "run-out period" that extends until March 31, 2012. However, the "grace period" mentioned above does not apply to this account. You may not submit reimbursement requests for expenses that occur after December 31, 2011 against the 2011 Plan Year.

Claims will be processed in the order in which they are received by FBMC, and your accounts will be debited accordingly. This is true for both paper claims and myFBMC Card® transactions. If you have funds remaining in an account for the prior plan year, these funds will be used first until exhausted. Then, subsequent claims will be debited from your new plan year account balance.

myFBMC Visa® Card®

The myFBMC Card® Visa® Card is issued by UMB.

What is the myFBMC Card®?

The myFBMC Card® is a stored-value card. It is a convenient Medical Expense FSA reimbursement option that allows FBMC to electronically reimburse eligible expenses under your employer's plan and IRS guidelines. Your annual Medical Expense FSA contribution is available to you at the beginning of your plan year. When you use your myFBMC Card® to pay for eligible expenses, funds are electronically deducted from your Medical Expense FSA.

What are the myFBMC Card® advantages?

You can use your myFBMC Card® for your eligible Over-the-Counter (OTC) expenses! Other advantages include:

- instant reimbursements for health care expenses, including prescriptions, co-payments and mail-order prescription services
- instant substantiation of some medical, prescription, vision and dental expenses
- no out-of-pocket expense and
- easy access to your Medical Spending Account funds.

You **cannot** use your myFBMC Card® for cosmetic dental expenses or eyeglass warranties.

How do I get a myFBMC Card®?

When you start a Medical Expense FSA, you will automatically receive the myFBMC Card®. Two cards will be sent to you in the mail; one for you, and one for your spouse or eligible dependent. You should retain your cards for use each plan year until their expiration date.

How do I use the myFBMC Card®?

For eligible expenses, simply swipe your myFBMC Card® like you would with any other credit card. Whether at your health care provider or at your drugstore, the amount of your eligible expenses will be automatically deducted from your Medical Expense FSA. For Over-the-Counter and prescription purchases, the card will only be accepted at IIAS merchants. For all other qualified expenses, such as medical co-payments, the myFBMC Card® will be used normally. To find out if a pharmacy or drugstore near you accepts the card, please refer to the **IIAS Store List at www.myFBMC.com**.

Visit www.myFBMC.com to access your account, activate your card and to see a list of participating drugstores.

When do I send in documentation for an myFBMC Card® expense?

You may need to send in documentation for certain myFBMC Card® transactions, such as those that are **not** a known office visit or prescription co-payment (as outlined in your health plan's Schedule of Benefits). When requested, you must send in documentation for these transactions. Documentation for an myFBMC Card® expense is a statement or bill showing:

- name of the patient
- name of the service provider
- date of service
- type of service (including prescription name) and
- total amount of service.

NOTE: This documentation must be sent with a FBMC Claim Form and cannot be processed without it. Like all other FSA documentation, you must keep your myFBMC Card® expense documentation for a minimum of one year, and submit it to FBMC when requested.

As an FSA participant, you should go to **www.myFBMC.com** to see your account information and check for any outstanding Card transactions. If an outstanding transaction appears in **red** on the Web site or in **blue** in the *Outstanding Card Transactions Requiring Documentation* section of your monthly statement, you must submit the proper expense documentation to FBMC prior to the end of your run out period.

If you fail to send in the requested documentation for an myFBMC Card® expense, you will be subject to:

- withholding of payment for an eligible paper claim to offset any outstanding myFBMC Card® transaction
- suspension of your myFBMC Card® privileges
- the reporting of any outstanding myFBMC Card® transaction amounts as income on your W-2 at the end of the tax year.

What agreement am I making when I use the myFBMC Card®?

By using the myFBMC Card®, you are agreeing to the "FSA Guidelines" portion of the online reference guide.

What happens if I have money left in my account at the end of the plan year?

These funds will be used first until exhausted — through March 15, 2012, which is the grace period allowed by the IRS. Then, subsequent claims will be debited from your new plan year account balance. For more information on the grace period, see Page 63.

MetLife Dental Comparison Chart

You may choose one of four dental plans, offered by SafeGuard, a MetLife Company and Metropolitan Life. Select one of the SafeGuard DHMO Plans or one of the MetLife IndemnityDental Plans. Indicated below is a comparison chart of all the plans.

	SAFEGUARD (Standard DHMO) SGC1033	SAFEGUARD (High DHMO) SGC1034	METLIFE Standard Plan		METLIFE High Plan	
	• Low co-payments • No deductible • Use panel dentist	• Low co-payments • No deductible • Use panel dentist	• In-Network* and Out-of-Network Benefits • Choose a MetLife Preferred Dentist for lower out-of-pocket costs			
ANNUAL CALENDAR YEAR DEDUCTIBLE (deductible applies to)	**None N/A**	**None N/A**	**IN-NETWORK* None N/A**	**OUT-OF-NETWORK $50/person $150/family (types A,B,C)**	**IN-NETWORK* $50/person $150/family (types B,C)**	**OUT-OF-NETWORK $50/person $150/ family (types A,B,C)**
Annual calendar year maximum benefit (per person)	**None**	**None**	**$1500 (types A,B,C)**	**$1500 (types A,B,C)**	**$1500 (types A,B,C)**	**$1500 (types A,B,C)**
	EMPLOYEE PAYS	*EMPLOYEE PAYS*	*EMPLOYEE PAYS*	*PLAN PAYS*	*PLAN PAYS*	*PLAN PAYS*
TYPE A						
Office visit	$5	$5	No Charge	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Oral exam	No Charge	No Charge	$5	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Prophylaxis (routine cleaning)	No Charge	No Charge	$15	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
TYPE B						
Amalgam (fillings)						
2 surface (adult)	$25	No Charge	$45	60% of PDP fees**	80% of PDP fees*	80% of PDP fees**
3 surface (adult)	$30	No Charge	$55	60% of PDP fees**	80% of PDP fees*	80% of PDP fees**
TYPE C						
Endodontics (root canals)						
Anterior	$200	$80	$300	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Bicuspid	$210	$115	$355	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Molar	$310	$200	$490	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Partial Dentures						
Resin Base	$375	$240	$420	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Cast Metal Framework	$375	$260	$820	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Periodontics (gum treatment)	$45 (1-3 teeth)	$30 (1-3 teeth)				
	$60 (4 or more teeth)	$40 (4+ teeth)	$85 per quadrant	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Scaling & root planing	$248 (1-3 teeth)	$210 (1-3 teeth)	$460 per quadrant	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Osseous surgery	$330 (4+ teeth)	$295 (4+ teeth)				
Crowns						
Porcelain to metal	$370	$280	$475	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Post & Core (in addition to crown)	$60	$60	$125			
Cosmetic Procedures						
Labial veneers (bonding)	$350 $125/Arch	$280 $125/Arch	N/A	N/A	N/A	N/A
Tooth bleaching	R&C less 25%	R&C less 25%	N/A	N/A	N/A	N/A
TYPE D						
Orthodontia (braces)						
Evaluation	$35	$0		50% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Treatment plan & records	$250	$250		50% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Child	$2095	$1800		50% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Adult	$2095	$1800		50% of PDP fees*	50% of PDP fees*	50% of PDP fees**
Lifetime maximum benefit per person	N/A	N/A	$2100***	$1500	$1500	$1500

† South Florida (Area 3) consists of zip codes that begin with the digits 330, 331, 333, 334, 339, 340, 349, 320-329, 335-338, 341-348. If you do not reside in a zip code that begins with these digits, please contact MetLife at 1-800-942-0854 for a more accurate in-network schedule of benefits and fees.

* In-Network: Member pays balance of PDP fees, after plan pays.

** Out-of-Network: Member pays balance of PDP fees, in addition to the remaining balance of claim. Balance equals the difference between total claim and PDP fee. For information on PDP fees in your area, contact MetLife directly at 1-800-942-0854.

*** The co-payment amount for a full course of treatment is $3600 minus your plan's lifetime orthodontic benefit maximum of $1500 ($3600 - $1500 = $2100).

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA.

See Page 58 for a partial list of eligible expenses or visit FBMC's Web site at www.myFBMC.com for the full version of eligible expenses.

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions and Limitations. SafeGuard is an affiliate of MetLife.

During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist. Your SafeGuard selected general dentist will refer you directly to a contracted SafeGuard specialty care provider; no additional referral or pre-authorization from SafeGuard is required. However, you cannot go to a specialist without a referral/ recommendation from the general dentist.

In addition, all non-listed services are available with your SafeGuard selected general dentist or specialty care dentist at 75% of their usual and customary fees.

Missed Appointments: If you need to cancel or reschedule an appointment, you should notify the dental office as far in advance as possible. This will allow the dental office to accommodate another person in need of attention. There could be up to a $25 charge for missed appointments.

SafeGuard Standard DHMO Plan - SGC1033

Schedule of Benefits

Diagnostic Treatment		member pays
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral Evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$10
	• Office visit - per visit (including all fees for sterilization and/or infection control)	$5

Radiographs / Diagnostic Imaging		member pays
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0273	Bitewings- three films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	Panoramic film	$0
D0350	Oral/facial photographic images	$0

Tests and Examinations		member pays
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjuctive pre-diagnostic test that aids in detection of mucosal abnormalties including premalignant and malignant lesions, not to include cytology or biopsy procedure	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0

Preventive Services		member pays
D1110	Prophylaxis - adult	$0
	• Additional - adult prophylaxis, with or without fluoride(maximum of 2 additional per year)	$35
D1120	Prophylaxis - child	$0
	• Additional - child prophylaxis, with or without fluoride(maximum of 2 additional per year)	$35
D1203	Topical application of fluoride (prophylaxis not included) - child	$0
D1204	Topical application of fluoride (prophylaxis not included) - adult	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1510	Space maintainer - fixed - unilateral	$65
D1515	Space maintainer - fixed - bilateral	$65
D1520	Space maintainer - removable - unilateral	$105
D1525	Space maintainer - removable - bilateral	$105
D1550	Re-cementation of space maintainer	$15
D1555	Removal of fixed space maintainer	$15

Restorative Treatment		member pays
D2140	Amalgam - one surface, primary or permanent	$20
D2150	Amalgam - two surfaces, primary or permanent	$25
D2160	Amalgam - three surfaces, primary or permanent	$30

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA.
See Page 58 for a partial list of eligible expenses or visit FBMC's Web site at www.myFBMC.com for the full version of eligible expenses.

D2161	Amalgam - four or more surfaces, primary or permanent	$35
D2330	Resin-based composite - one surface, anterior	$35
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$50
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$55
D2390	Resin-based composite crown, anterior	$65
D2391	Resin-based composite - one surface, posterior	$75
D2392	Resin-based composite - two surfaces, posterior	$85
D2393	Resin-based composite - three surfaces, posterior	$95
D2394	Resin-based composite - four or more surfaces, posterior	$120

Crowns **member pays**

- An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is no co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
- Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.

D2510	Inlay - metallic - one surface	$155
D2520	Inlay - metallic - two surfaces	$165
D2530	Inlay - metallic - three or more surfaces	$190
D2542	Onlay - metallic - two surfaces	$370
D2543	Onlay - metallic - three surfaces	$370
D2544	Onlay - metallic - four or more surfaces	$370
D2610	Inlay - porcelain/ceramic - one surface	$370
D2620	Inlay - porcelain/ceramic - two surfaces	$370
D2630	Inlay - porcelain/ceramic - three or more surfaces	$370
D2642	Onlay - porcelain/ceramic - two surfaces	$370
D2643	Onlay - porcelain/ceramic - three surfaces	$370
D2644	Onlay - porcelain/ceramic - four or more surfaces	$370
D2650	Inlay - resin-based composite - one surface	$370
D2651	Inlay - resin-based composite - two surfaces	$370
D2652	Inlay - resin-based composite - three or more surfaces	$370
D2662	Onlay - resin-based composite - two surfaces	$370
D2663	Onlay - resin-based composite - three surfaces	$370
D2664	Onlay - resin-based composite - four or more surfaces	$370
D2710	Crown - resin-based composite (indirect)	$370
D2712	Crown - 3/4 resin-based composite (indirect)	$370
D2720	Crown - resin with high noble metal	$370
D2721	Crown - resin with predominantly base metal	$370
D2722	Crown - resin with noble metal	$370
D2740	Crown - porcelain/ceramic substrate	$370
D2750	Crown - porcelain fused to high noble metal	$370
D2751	Crown - porcelain fused to predominantly base metal	$370
D2752	Crown - porcelain fused to noble metal	$370
D2780	Crown - 3/4 cast high noble metal	$370
D2781	Crown - 3/4 cast predominantly base metal	$370
D2782	Crown - 3/4 cast noble metal	$370
D2783	Crown - 3/4 porcelain/ceramic	$370
D2790	Crown - full cast high noble metal	$370
D2791	Crown - full cast predominantly base metal	$370
D2792	Crown - full cast noble metal	$370
D2794	Crown – titanium	$370
D2799	Provisional crown	$0
D2910	Recement inlay, onlay, or partial coverage restoration	$15
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$15
D2930	Prefabricated stainless steel crown - primary tooth	$25
D2931	Prefabricated stainless steel crown - permanent tooth	$25
D2932	Prefabricated resin crown	$45
D2933	Prefabricated stainless steel crown with resin window	$45
D2940	Sedative filling	$0
D2950	Core build up, including any pins	$60
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Cast post and core in addition to crown	$60
D2953	Each additional cast post - same tooth	$60
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2957	Each additional prefabricated post - same tooth	$30
D2960	Labial veneer (resin laminate) - chairside	$250
D2961	Labial veneer (resin laminate) - laboratory	$300
D2962	Labial veneer (porcelain laminate) - laboratory	$350
D2970	Temporary crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2980	Crown repair, by report	$0

Endodontics **member pays**

All procedures exclude final restoration

D3110	Pulp cap - direct (excluding final restoration)	$5
D3120	Pulp cap - indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40
D3221	Pulpal debridement, primary and permanent teeth	$60
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth(excluding final restoration)	$40
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth(excluding final restoration)	$40
D3310	Anterior (excluding final restoration)	$200
D3320	Bicuspid (excluding final restoration)	$210
D3330	Molar (excluding final restoration)	$310
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$110
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy – anterior	$230
D3347	Retreatment of previous root canal therapy – bicuspid	$280
D3348	Retreatment of previous root canal therapy – molar	$325
D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$70
D3352	Apexification/recalcification - interim visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$70
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3410	Apicoectomy/periradicular surgery – anterior	$190
D3421	Apicoectomy/periradicular surgery - bicuspid (1st root)	$95
D3425	Apicoectomy/periradicular surgery - molar (1st root)	$95
D3426	Apicoectomy/periradicular surgery (each additional root)	$80
D3430	Retrograde filling - per root	$60
D3450	Root amputation - per root	$110
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal) not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15

Periodontics		member pays
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$180
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$55
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$170
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$130
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening - hard tissue	$160
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$330
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$248
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration - resorbable barrier, per site	$215
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$255
D4270	Pedicle soft tissue graft procedure	$250
D4271	Free soft tissue graft procedure (including donor site surgery)	$260
D4273	Subephithelial connective tissue graft procedure, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$100
D4275	Soft tissue allograft	$380
D4320	Provisional splinting – intracoronal	$95
D4321	Provisional splinting – extracoronal	$85
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$60
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$45
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$50
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$60
D4910	Periodontal maintenance	$50
	• Additional periodontal maintenance procedures (beyond 2 per 12 months)	$60
	• Periodontal charting for planning treatment of periodontal disease	$0
	• Periodontal hygiene instruction	$0

Removable Prosthodontics		member pays
Includes up to 3 adjustments within 6 months of delivery.		
D5110	Complete denture – maxillary	$375
D5120	Complete denture - mandibular	$375
D5130	Immediate denture - maxillary	$375
D5140	Immediate denture - mandibular	$375
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$375
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$375
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$375
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$375
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$480
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$480
D5281	Removable unilateral partial denture - one piece cast metal(including clasps and teeth)	$360
D5410	Adjust complete denture – maxillary	$20
D5411	Adjust complete denture – mandibular	$20
D5421	Adjust partial denture – maxillary	$20
D5422	Adjust partial denture – mandibular	$20
D5510	Repair broken complete denture base	$30
D5520	Replace missing or broken teeth - complete denture (each tooth)	$30
D5610	Repair resin denture base	$30
D5620	Repair cast framework	$50
D5630	Repair or replace broken clasp	$30
D5640	Replace broken teeth - per tooth	$30
D5650	Add tooth to existing partial denture	$45
D5660	Add clasp to existing partial denture	$70
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$125
D5711	Rebase complete mandibular denture	$125
D5720	Rebase maxillary partial denture	$125
D5721	Rebase mandibular partial denture	$125
D5730	Reline complete maxillary denture (chairside)	$65
D5731	Reline complete mandibular denture (chairside)	$65
D5740	Reline maxillary partial denture (chairside)	$65
D5741	Reline mandibular partial denture (chairside)	$65
D5750	Reline complete maxillary denture (laboratory)	$50
D5751	Reline complete mandibular denture (laboratory)	$50
D5760	Reline maxillary partial denture (laboratory)	$50
D5761	Reline mandibular partial denture (laboratory)	$50
D5810	Interim complete denture (maxillary)	$230
D5811	Interim complete denture (mandibular)	$230
D5820	Interim partial denture (maxillary)	$160
D5821	Interim partial denture (mandibular)	$170
D5850	Tissue conditioning, maxillary	$40
D5851	Tissue conditioning, mandibular	$40
D5862	Precision attachment, by report	$160

Crowns/Fixed Bridges - Per Unit — **member pays**

- An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is no co-payment per crown bridge unit in addition to regular co-payments for porcelain on molars.
- Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.

D6210	Pontic - cast high noble metal	$370

D6211	Pontic - cast predominantly base metal	$370
D6212	Pontic - cast noble metal	$370
D6214	Pontic - titanium	$370
D6240	Pontic - porcelain fused to high noble metal	$370
D6241	Pontic - porcelain fused to predominantly base metal	$370
D6242	Pontic - porcelain fused to noble metal	$370
D6245	Pontic - porcelain/ceramic	$370
D6250	Pontic - resin with high noble metal	$370
D6251	Pontic - resin with predominantly base metal	$370
D6252	Pontic - resin with noble metal	$370
D6253	Provisional pontic	$0
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$370
D6600	Inlay - porcelain/ceramic, two surfaces	$370
D6601	Inlay - porcelain/ceramic, three or more surfaces	$370
D6602	Inlay - cast high noble metal, two surfaces	$370
D6603	Inlay - cast high noble metal, three or more surfaces	$370
D6604	Inlay - cast predominantly base metal, two surfaces	$370
D6605	Inlay - cast predominantly base metal, three or more surfaces	$370
D6606	Inlay - cast noble metal, two surfaces	$370
D6607	Inlay - cast noble metal, three or more surfaces	$370
D6608	Onlay - porcelain/ceramic, two surfaces	$370
D6609	Onlay - porcelain/ceramic, three or more surfaces	$370
D6610	Onlay - cast high noble metal, two surfaces	$370
D6611	Onlay - cast high noble metal, three or more surfaces	$370
D6612	Onlay - cast predominantly base metal, two surfaces	$370
D6613	Onlay - cast predominantly base metal, three or more surfaces	$370
D6614	Onlay - cast noble metal, two surfaces	$370
D6615	Onlay - cast noble metal, three or more surfaces	$370
D6710	Crown - indirect resin based composite	$370
D6720	Crown - resin with high noble metal	$370
D6721	Crown - resin with predominantly base metal	$370
D6722	Crown - resin with noble metal	$370
D6740	Crown - porcelain/ceramic	$370
D6750	Crown - porcelain fused to high noble metal	$370
D6751	Crown - porcelain fused to predominantly base metal	$370
D6752	Crown - porcelain fused to noble metal	$370
D6780	Crown - 3/4 cast high noble metal	$370
D6781	Crown - 3/4 cast predominantly base metal	$370
D6782	Crown - 3/4 cast noble metal	$370
D6783	Crown - 3/4 porcelain/ceramic	$370
D6790	Crown - full cast high noble metal	$370
D6791	Crown - full cast predominantly base metal	$370
D6792	Crown - full cast noble metal	$370
D6794	Crown - titanium	$370
D6930	Recement fixed partial denture	$15
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6970	Cast post and core in addition to fixed partial denture retainer	$50
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$30
D6973	Core build up for retainer, including any pins	$10
D6976	Each additional cast post - same tooth	$40
D6977	Each additional prefabricated post - same tooth	$40
D6980	Fixed partial denture repair, by report	$45

Oral Surgery — member pays

- Includes routine post operative visits/treatment.
- The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your SafeGuard selected general or specialty care dentist's usual and customary fees.

D7111	Extraction, coronal remnants - deciduous tooth	$20
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$20
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth - soft tissue	$75
D7230	Removal of impacted tooth - partially bony	$85
D7240	Removal of impacted tooth - completely bony	$135
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$150
D7250	Surgical removal of residual tooth roots (cutting procedure)	$65
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$80
D7280	Surgical access of an impacted unerupted tooth	$100
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Biopsy of oral tissue - hard (bone, tooth)	$150
D7286	Biopsy of oral tissue - soft	$60
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$50
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$45
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$100
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess - intraoral soft tissue	$35
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$35
D7520	Incision and drainage of abscess - extraoral soft tissue	$35
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$35
D7910	Suture of recent small wounds up to 5 cm	$25
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$90
D7963	Frenuloplasty	$90
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of pericoronal gingival	$40

Orthodontics — member pays

(See Continuing Orthodontic Treatment information on the following page.)

- Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.
- Comprehensive orthodontic benefits include all phases of treatment and fixed/removable appliances.

D8010	Limited orthodontic treatment of the primary dentition	$1,095

D8020	Limited orthodontic treatment of the transitional dentition	$1,095
D8030	Limited orthodontic treatment of the adolescent dentition	$1,095
D8040	Limited orthodontic treatment of the adult dentition	$1,095
D8050	Interceptive orthodontic treatment of the primary dentition	25% Discount
D8060	Interceptive orthodontic treatment of the transitional dentition	25% Discount
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,095
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,095
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,095
D8210	Removable appliance therapy	25% Discount
D8220	Fixed appliance therapy	25% Discount
D8660	Pre-orthodontic treatment visit	$35
D8670	Periodic orthodontic treatment visit (as part of contract)	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0
	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250
	Orthodontic visits beyond 24 months of active treatment or retention	$25 per visit

Adjunctive General Services		**member pays**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$15
D9120	Fixed partial denture sectioning	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia - first 30 minutes	$150
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$150
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$45
D9248	Non-intravenous conscious sedation	$15
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$5
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic drug injection, by report	$15
D9612	Therapeutic parental drugs, two or more administrations, different medications	$25
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$85
D9942	Repair and/or reline of occlusal guard	$40
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$100
D9972	External bleaching - per arch	$125
	• Broken appointment (less than 24 hour notice) Not to exceed	$25

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

Plan Provider: SafeGuard, a Metropolitan Life Insurance Company.

SafeGuard Standard DHMO Plan

	10-MONTH (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$4.48	$3.73	$3.44
Employee & Family	$11.41	$9.51	$8.78

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions and Limitations. SafeGuard is an affiliate of MetLife.

During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist. Your SafeGuard selected general dentist will refer you directly to a contracted SafeGuard specialty care provider; no additional referral or pre-authorization from SafeGuard is required. However, you cannot go to a specialist without a referral/ recommendation from the general dentist.

In addition, all non-listed services are available with your SafeGuard selected general dentist or specialty care dentist at 75% of their usual and customary fees.

Missed Appointments: If you need to cancel or reschedule an appointment, you should notify the dental office as far in advance as possible. This will allow the dental office to accommodate another person in need of attention. There could be up to a $25 charge for missed appointments.

SafeGuard High DHMO Plan - SGC1034

Schedule of Benefits

Diagnostic Treatment		member pays
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral Evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$10
	• Office visit - per visit (including all fees for sterilization and/or infection control)	$5

Radiographs / Diagnostic Imaging		member pays
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0273	Bitewings- three films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	Panoramic film	$0
D0350	Oral/facial photographic images	$0

Tests and Examinations		member pays
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjuctive pre-diagnostic test that aids in detection of mucosal abnormalties including premalignant and malignant lesions, not to include cytology or biopsy procedure	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0

Preventive Services		member pays
D1110	Prophylaxis - adult	$0
	• Additional - adult prophylaxis, with or without fluoride(maximum of 2 additional per year)	$20
D1120	Prophylaxis - child	$0
	• Additional - child prophylaxis, with or without fluoride(maximum of 2 additional per year)	$20
D1203	Topical application of fluoride (prophylaxis not included) - child	$0
D1204	Topical application of fluoride (prophylaxis not included) - adult	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$5
D1510	Space maintainer - fixed - unilateral	$45
D1515	Space maintainer - fixed - bilatera	$45
D1520	Space maintainer - removable - unilateral	$85
D1525	Space maintainer - removable - bilateral	$85
D1550	Re-cementation of space maintainer	$5
D1555	Removal of fixed space maintainer	$5

Restorative Treatment		member pays
D2140	Amalgam - one surface, primary or permanent	$0
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA.
See Page 58 for a partial list of eligible expenses or visit FBMC's Web site at www.myFBMC.com for the full version of eligible expenses.

SafeGuard, a MetLife Insurance Company

D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$35
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$50
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$55
D2390	Resin-based composite crown, anterior	$70
D2391	Resin-based composite - one surface, posterior	$60
D2392	Resin-based composite - two surfaces, posterior	$80
D2393	Resin-based composite - three surfaces, posterior	$90
D2394	Resin-based composite - four or more surfaces, posterior	$120

Crowns **member pays**

- An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is no co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
- Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.

D2510	Inlay - metallic - one surface	$95
D2520	Inlay - metallic - two surfaces	$105
D2530	Inlay - metallic - three or more surfaces	$130
D2542	Onlay - metallic - two surfaces	$230
D2543	Onlay - metallic - three surfaces	$230
D2544	Onlay - metallic - four or more surfaces	$230
D2610	Inlay - porcelain/ceramic - one surface	$230
D2620	Inlay - porcelain/ceramic - two surfaces	$230
D2630	Inlay - porcelain/ceramic - three or more surfaces	$230
D2642	Onlay - porcelain/ceramic - two surfaces	$230
D2643	Onlay - porcelain/ceramic - three surfaces	$230
D2644	Onlay - porcelain/ceramic - four or more surfaces	$230
D2650	Inlay - resin-based composite - one surface	$230
D2651	Inlay - resin-based composite - two surfaces	$230
D2652	Inlay - resin-based composite - three or more surfaces	$230
D2662	Onlay - resin-based composite - two surfaces	$230
D2663	Onlay - resin-based composite - three surfaces	$230
D2664	Onlay - resin-based composite - four or more surfaces	$230
D2710	Crown - resin-based composite (indirect)	$230
D2712	Crown - 3/4 resin-based composite (indirect)	$230
D2720	Crown - resin with high noble metal	$230
D2721	Crown - resin with predominantly base metal	$230
D2722	Crown - resin with noble metal	$230
D2740	Crown - porcelain/ceramic substrate	$280
D2750	Crown - porcelain fused to high noble metal	$280
D2751	Crown - porcelain fused to predominantly base metal	$280
D2752	Crown - porcelain fused to noble metal	$280
D2780	Crown - 3/4 cast high noble metal	$230
D2781	Crown - 3/4 cast predominantly base metal	$230
D2782	Crown - 3/4 cast noble metal	$230
D2783	Crown - 3/4 porcelain/ceramic	$230
D2790	Crown - full cast high noble metal	$280
D2791	Crown - full cast predominantly base metal	$280
D2792	Crown - full cast noble metal	$280
D2794	Crown – titanium	$230
D2799	Provisional crown	$0
D2910	Recement inlay, onlay, or partial coverage restoration	$10
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$10
D2930	Prefabricated stainless steel crown - primary tooth	$25
D2931	Prefabricated stainless steel crown - permanent tooth	$25
D2932	Prefabricated resin crown	$35
D2933	Prefabricated stainless steel crown with resin window	$35
D2940	Sedative filling	$10
D2950	Core build up, including any pins	$45
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Cast post and core in addition to crown	$60
D2953	Each additional cast post - same tooth	$60
D2954	Prefabricated post and core in addition to crown	$60
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2957	Each additional prefabricated post - same tooth	$30
D2960	Labial veneer (resin laminate) - chairside	$250
D2961	Labial veneer (resin laminate) - laboratory	$300
D2962	Labial veneer (porcelain laminate) - laboratory	$350
D2970	Temporary crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2980	Crown repair, by report	$0

Endodontics **member pays**

All procedures exclude final restoration

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$10
D3221	Pulpal debridement, primary and permanent teeth	$45
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth(excluding final restoration)	$30
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth(excluding final restoration)	$35
D3310	Anterior (excluding final restoration)	$80
D3320	Bicuspid (excluding final restoration)	$115
D3330	Molar (excluding final restoration)	$200
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy – anterior	$135
D3347	Retreatment of previous root canal therapy – bicuspid	$175
D3348	Retreatment of previous root canal therapy – molar	$275
D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$65
D3352	Apexification/recalcification - interim visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$65
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3410	Apicoectomy/periradicular surgery – anterior	$95
D3421	Apicoectomy/periradicular surgery - bicuspid (1st root)	$95
D3425	Apicoectomy/periradicular surgery - molar (1st root)	$95
D3426	Apicoectomy/periradicular surgery (each additional root)	$60
D3430	Retrograde filling - per root	$40
D3450	Root amputation - per root	$95
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal) not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15

Periodontics		member pays
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$125
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$40
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$113
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening - hard tissue	$120
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$295
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$210
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration - resorbable barrier, per site	$215
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$255
D4270	Pedicle soft tissue graft procedure	$245
D4271	Free soft tissue graft procedure (including donor site surgery)	$245
D4273	Subephithelial connective tissue graft procedure, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4275	Soft tissue allograft	$380
D4320	Provisional splinting – intracoronal	$95
D4321	Provisional splinting – extracoronal	$85
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$40
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$45
D4910	Periodontal maintenance	$30
	• Additional periodontal maintenance procedures (beyond 2 per 12 months)	$55
	• Periodontal charting for planning treatment of periodontal disease	$0
	• Periodontal hygiene instruction	$0

Removable Prosthodontics		member pays
Includes up to 3 adjustments within 6 months of delivery.		
D5110	Complete denture – maxillary	$210
D5120	Complete denture - mandibular	$210
D5130	Immediate denture - maxillary	$225
D5140	Immediate denture - mandibular	$225
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$240
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$240
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$260
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$260
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365
D5281	Removable unilateral partial denture - one piece cast metal(including clasps and teeth)	$250
D5410	Adjust complete denture – maxillary	$0
D5411	Adjust complete denture – mandibular	$0
D5421	Adjust partial denture – maxillary	$0
D5422	Adjust partial denture – mandibular	$0
D5510	Repair broken complete denture base	$15
D5520	Replace missing or broken teeth - complete denture (each tooth)	$15
D5610	Repair resin denture base	$15
D5620	Repair cast framework	$30
D5630	Repair or replace broken clasp	$15
D5640	Replace broken teeth - per tooth	$15
D5650	Add tooth to existing partial denture	$30
D5660	Add clasp to existing partial denture	$35
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$60
D5711	Rebase complete mandibular denture	$60
D5720	Rebase maxillary partial denture	$60
D5721	Rebase mandibular partial denture	$60
D5730	Reline complete maxillary denture (chairside)	$35
D5731	Reline complete mandibular denture (chairside)	$35
D5740	Reline maxillary partial denture (chairside	$35
D5741	Reline mandibular partial denture (chairside)	$35
D5750	Reline complete maxillary denture (laboratory)	$35
D5751	Reline complete mandibular denture (laboratory)	$35
D5760	Reline maxillary partial denture (laboratory)	$35
D5761	Reline mandibular partial denture (laboratory)	$35
D5810	Interim complete denture (maxillary)	$230
D5811	Interim complete denture (mandibular)	$230
D5820	Interim partial denture (maxillary)	$60
D5821	Interim partial denture (mandibular)	$60
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$160

Crowns/Fixed Bridges - Per Unit — **member pays**

- An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is no co-payment per crown bridge unit in addition to regular co-payments for porcelain on molars.
- Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.

D6210	Pontic - cast high noble metal	$280

D6211	Pontic - cast predominantly base metal	$280
D6212	Pontic - cast noble metal	$280
D6214	Pontic - titanium	$280
D6240	Pontic - porcelain fused to high noble metal	$280
D6241	Pontic - porcelain fused to predominantly base metal	$280
D6242	Pontic - porcelain fused to noble metal	$280
D6245	Pontic - porcelain/ceramic	$250
D6250	Pontic - resin with high noble metal	$230
D6251	Pontic - resin with predominantly base metal	$230
D6252	Pontic - resin with noble metal	$230
D6253	Provisional pontic	$0
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$200
D6600	Inlay - porcelain/ceramic, two surfaces	$230
D6601	Inlay - porcelain/ceramic, three or more surfaces	$230
D6602	Inlay - cast high noble metal, two surfaces	$230
D6603	Inlay - cast high noble metal, three or more surfaces	$230
D6604	Inlay - cast predominantly base metal, two surfaces	$230
D6605	Inlay - cast predominantly base metal, three or more surfaces	$230
D6606	Inlay - cast noble metal, two surfaces	$230
D6607	Inlay - cast noble metal, three or more surfaces	$230
D6608	Onlay - porcelain/ceramic, two surfaces	$230
D6609	Onlay - porcelain/ceramic, three or more surfaces	$230
D6610	Onlay - cast high noble metal, two surfaces	$230
D6611	Onlay - cast high noble metal, three or more surfaces	$230
D6612	Onlay - cast predominantly base metal, two surfaces	$230
D6613	Onlay - cast predominantly base metal, three or more surfaces	$230
D6614	Onlay - cast noble metal, two surfaces	$230
D6615	Onlay - cast noble metal, three or more surfaces	$230
D6710	Crown - indirect resin based composite	$230
D6720	Crown - resin with high noble metal	$230
D6721	Crown - resin with predominantly base metal	$230
D6722	Crown - resin with noble metal	$230
D6740	Crown - porcelain/ceramic	$230
D6750	Crown - porcelain fused to high noble metal	$230
D6751	Crown - porcelain fused to predominantly base metal	$230
D6752	Crown - porcelain fused to noble metal	$230
D6780	Crown - 3/4 cast high noble metal	$230
D6781	Crown - 3/4 cast predominantly base metal	$230
D6782	Crown - 3/4 cast noble metal	$230
D6783	Crown - 3/4 porcelain/ceramic	$230
D6790	Crown - full cast high noble metal	$230
D6791	Crown - full cast predominantly base metal	$230
D6792	Crown - full cast noble metal	$230
D6794	Crown - titanium	$230
D6930	Recement fixed partial denture	$0
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6970	Cast post and core in addition to fixed partial denture retainer	$50
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$30
D6973	Core build up for retainer, including any pins	$10
D6976	Each additional cast post - same tooth	$40
D6977	Each additional prefabricated post - same tooth	$40
D6980	Fixed partial denture repair, by report	$45

Oral Surgery — member pays

- Includes routine post operative visits/treatment.
- The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your SafeGuard selected general or specialty care dentist's usual and customary fees.

D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$30
D7220	Removal of impacted tooth - soft tissue	$45
D7230	Removal of impacted tooth - partially bony	$65
D7240	Removal of impacted tooth - completely bony	$80
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$100
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7280	Surgical access of an impacted unerupted tooth	$85
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Biopsy of oral tissue - hard (bone, tooth)	$0
D7286	Biopsy of oral tissue - soft	$0
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$50
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$35
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$70
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess - intraoral soft tissue	$25
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30
D7520	Incision and drainage of abscess - extraoral soft tissue	$30
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30
D7910	Suture of recent small wounds up to 5 cm	$25
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$40
D7963	Frenuloplasty	$40
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of pericoronal gingival	$35

Orthodontics — member pays

(See Continuing Orthodontic Treatment information on the following page.)

- Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.
- Comprehensive orthodontic benefits include all phases of treatment and fixed/removable appliances.

D8010	Limited orthodontic treatment of the primary dentition	$1,000

D8020	Limited orthodontic treatment of the transitional dentition	$1,000
D8030	Limited orthodontic treatment of the adolescent dentition	$1,000
D8040	Limited orthodontic treatment of the adult dentition	$1,000
D8050	Interceptive orthodontic treatment of the primary dentition	25% Discount
D8060	Interceptive orthodontic treatment of the transitional dentition	25% Discount
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,800
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,800
D8210	Removable appliance therapy	25% Discount
D8220	Fixed appliance therapy	25% Discount
D8660	Pre-orthodontic treatment visit	$0
D8670	Periodic orthodontic treatment visit (as part of contract)	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0
	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250
	Orthodontic visits beyond 24 months of active treatment or retention $25 per visit	

Adjunctive General Services		member pays
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10
D9120	Fixed partial denture sectioning	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia - first 30 minutes	$150
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$150
D9242	Intravenous conscious sedation/analgesia - each additional 15minutes	$45
D9248	Non-intravenous conscious sedation	$15
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$0
D9430	Office visit for observation (during regularly scheduled hours) -no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic drug injection, by report	$15
D9612	Therapeutic parental drugs, two or more administrations, different medications	$25
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$85
D9942	Repair and/or reline of occlusal guard	$40
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$100
D9972	External bleaching - per arch	$125
	• Broken appointment (less than 24 hour notice) Not to exceed	$25

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee.

To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under “Important Phone Numbers.”

Plan Provider: SafeGuard, a Metropolitan Life Insurance Company.

SafeGuard High DHMO Plans

	10-MONTH (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$6.34	$5.28	$4.87
Employee & Family	$16.17	$13.48	$12.44

Dental Terminology Definitions

These definitions are designed to give you a "layman's understanding" of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam: A silver filling
Anterior: Teeth that are in the front of the mouth
Bicuspid: Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.
Bridge: A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).
Crown: A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.
Endodontics: Procedures that treat the nerve or the pulp of the tooth due to injury or infection.
Oral Surgery: Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.
Orthodontics: Braces and other procedures to straighten the teeth.
Periodontics: Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).
Posterior: Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).
Primary Teeth: The first set of teeth ("baby" teeth).
Prophylaxis: Scaling and polishing of teeth by removal of the plaque above the gum line.
Prosthodontics: The restoration of natural and/or the replacement of missing teeth with artificial substitutes.
Quadrant: One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).
Resin-based Composite: Tooth-colored (white) fillings.

General Exclusions

1. Services performed by any dentist not contracted with SafeGuard, without prior approval by SafeGuard (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.
2. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken.
3. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard selected general dentist.
4. Orthognathic surgery.
5. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect.
7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.
8. Procedures, appliances, or restorations whose primary main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
9. Dental implants and services associated with the placement of implants, prosthodontics restoration of dental implants, and specialized implant maintenance services.
10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
11. Dental services required while serving in the Armed Forces of any country or international authority.
12. Dental services considered experimental in nature.
13. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.
14. Children up to age 8 must be assigned a General Dentist, and if desired, can be referred to a Pediatric Dentist for care. Children with special needs can be approved to see a Pediatric Dentist beyond the limiting age.

Limitations:

General

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are available at 75% of the usual and customary fees of the treating SafeGuard selected general or specialty care dentist, provided the services are included in the treatment plan and are not specifically excluded.
2. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the usual and customary fees of the treating SafeGuard selected general or specialty care dentist, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits.
3. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Preventive:

1. Routine Cleanings (prophylaxis), periodontal maintenance services, and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the co-payment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.
2. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

Diagnostic:

1. Panoramic or full-mouth X-rays: Once every three (3) years, unless medically necessary.

Restorative:

1. An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
2. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
3. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional $125 co-payment per unit in addition to the specified co-payment for each crown/bridge unit.
4. There is no co-payment per crown/bridge unit in addition to the specified co-payment for porcelain on molars.

Prosthodontics:

1. Relines are limited to one (1) every twelve (12) months.
2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard Plan, unless due to the loss of a natural functioning tooth. Replacements will be a benefit under this Plan only if the existing denture is unsatisfactory and cannot be made satisfactory as determined by the treating SafeGuard selected general dentist.
3. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

Endodontics:

1. The co-payments listed for endodontic procedures do not include the cost of the final restoration.

Oral Surgery:

1. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists, however it is available at 75% of your SafeGuard selected general or specialty care dentist's usual and customary fees.

Orthodontic Exclusions and Limitations:

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the member will be responsible for all costs associated with any orthodontic treatment. If you terminate coverage from the SafeGuard Plan after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. Orthodontic treatment must be provided by a SafeGuard selected general dentist or SafeGuard contracted orthodontist in order for the co-payments listed in this Plan's Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of $25 per visit.
3. The following are not included as orthodontic benefits:
   A. Repair or replacement of lost or broken appliances;
   B. Retreatment of orthodontic cases;
   C. Treatment involving:
      i. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
      ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
      iii. Treatment related to temporomandibular joint disorders;
      iv. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
5. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.

How to use dental benefits:

A list containing the Select Panel Providers in Miami-Dade, Broward, Monroe and Palm Beach Counties can be viewed online at **www.metlife.com/mybenefits**. You may call the SafeGuard Customer Services Department at 1-800-880-1800 to verify your dentist's continued participation in your selected plan.

How can I make an appointment with my SafeGuard dentist?

You may schedule an appointment by calling the dental office you selected on or after your effective date of coverage. When you call to schedule your appointment, inform the office that you are a member of the SafeGuard dental plan. It will not be necessary to use any claim forms. If you need to cancel your appointment for any reason, please let your provider know twenty-four (24) hours in advance of your scheduled appointment. The Benefits Schedule allows the provider to charge a fee (up to a maximum of $25) for any broken or cancelled appointment without twenty-four (24) hours notice.

Who is an eligible dependent for this coverage?

Eligible dependents for this plan include:

- Spouse/Domestic Partner
- Unmarried natural children, adopted children, and step-children under you or your spouse's legal guardianship until the end of the calendar year in which the child reaches age 26
- Children of a Domestic Partner, as long as the Domestic Partner is also covered.

NOTE: Children may be covered under this plan until the end of the calendar year in which the child reaches age 26, provided he/she is unmarried and resides in your home and depends upon you for support, or is registered as a full-time or part-time student. Children with a mental or physical handicap are also eligible for coverage beyond the age of 26.

What should I do if I wish to change my dentist selection?

You have control over your choice of dental offices and you can make changes at any time. If you would like to change your selected General Dentist Office, please contact SafeGuard Customer Service at (800) 880-1800. Associates will help you locate a dental office most convenient to you. The transfer will be effective on the fist day of the month following the transfer request. You must pay all outstanding charges owed to your dentist before you transfer to a new dentist. In addition, you may have to pay a fee for the cost of duplicating your x-rays and dental records.

What if I need the services of a Specialist?

During the course of treatment, your selected General Dentist may recommend the services of a dental specialist. Your selected general dentist will refer you directly to a contracted SafeGuard specialty care provider; no additional referral or pre-authorization from SafeGuard is required. You may also call customer service at (800) 880-1800 to get a list of specialists in your area.

What can I do if I have questions about the treatment plan prescribed by my General Dentist?

You may request a second opinion if you have unanswered questions about diagnosis, treatment plans and/or the results achieved by such dental treatment. Contact SafeGuard Customer Service at (800) 880-1800 or your selected General Dentist may request a second opinion on your behalf. Such requests are processed within five (5) business days of receipt, except when an expedited second opinion is warranted. Upon approval, SafeGuard will contact the consulting dentist and make arrangements to enable you to schedule an appointment. The fee for a a second opinion consultation is $5.

What if I'm currently seeing a dentist under one plan and I change plans to SafeGuard, but would like to maintain the same dentist?

As long as the dentist is part of the SafeGuard network and is accepting patients, you may select the facility as your primary dentist. If the facility is not open to new membership, you will have to select another participating provider.

How can I receive Emergency Care within the service area?

All selected General Dentist offices provide emergency dental services 24 hours a day, seven (7) days a week. If you require emergency dental services, you may go to any dental provider, the closest emergency room or call 911 for assistance as necessary. Prior authorization for emergency dental services is not required. Your reimbursement is limited to the extent that the treatment you received directly relates to emergency dental services. Hospital charges and/or other charges for care received an an outpatient care facility are not covered benefits. You will be required to pay the charges to the dentist and submit a claim to SafeGuard for a benefits determination. If you seek emergency dental services from a provider located more than 25 miles away from your selected GD, you will receive emergency benefits coverage up to a maximum of $50, less any applicable copayments. You must notify Customer Service within 48 hours after receiving such services. If your physical condition does not permit such notification, you must make the notification as soon as it is reasonably possible.

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to the SafeGuard Member Services Department at Miami-Dade: (305) 995-7029 or toll-free: (800) 880-1800. Representatives are available Monday - Friday, 8 a.m. - 6 p.m.,ET.

MetLife Indemnity Dental Plan

The MetLife dental plans are the traditional indemnity insurance plan whereby you and your family may select the dentist of your choice. MetLife offers you a choice of two different plans. The Standard Plan is a low cost plan that is designed for those individuals who primarily would need only diagnostic and preventive dental services. The Standard Plan includes a co-pay schedule that applies to the various dental procedures. You do not have to satisfy an annual calendar year deductible if you seek services from an in-network PDP dentist. The High Plan is designed for those individuals who have more extensive dental needs. This plan provides a reimbursement of either 100 percent, 80 percent or 50 percent of the plans Preferred Dental Program fees, depending on the service provided, after you have satisfied the plan deductible. MetLife offers quality dental care at affordable prices with their Preferred Dental Program (PDP). This program includes a nationwide network of dentists who have agreed to reduce their fees below the average reasonable and customary charge for their services. You are free to choose an in-network or out-of-network dentist at the time you make your appointment. However, when using an out-of-network dentist, the level of coverage is reduced and your out-of-pocket expenses will increase.

	STANDARD PLAN		HIGH PLAN	
	In-Network South Florida (Area 3)†	**Out-of-Network**	**In-Network South Florida (Area 3)†**	**Out-of-Network**
ANNUAL CALENDAR YEAR DEDUCTIBLE Deductible applies to	**None** N/A	**$50/person** $150/ family (type A,B,C)	**$50/ person** $150/ family (type B,C)	**$50/ person** $150/ family (type A,B,C)
ANNUAL CALENDAR YEAR MAXIMUM Maximum benefit allowed per person for Types A, B & C Combined	$1500	$1500	$1500	$1500
PREVENTIVE (Type A)	**EMPLOYEE PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
X-rays (bitewing 2 per year)	$0	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
X-rays (full mouth or panoramic every 3 years)	$0	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Cleaning and scaling (2 per year)	$15	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Fluoride treatment (up to age 19 - one per year)	$0	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
BASIC SERVICE (Type B)				
Space Maintainers - unilateral (up to age 19)	$105	60% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Sealants (Dependent child up to age 19 - once every 5 years on permanent molars only)	$15	60% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Amalgams (2 surfaces)	$45	60% of PDP fees**	80% of PDP fees*	80% of PDP fees**
Periodontics maintenance (unlimited after periodontic treatment)	$40	60% of PDP fees**	80% of PDP fees*	80% of PDP fees**
MAJOR SERVICE (Type C)				
Denture relining (chairside)	$105	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Denture adjustments	$30	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
General anesthesia (30 minutes)	$155	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Impacted Teeth	$145	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Periodontics (gum treatment) scaling and root planning	$85 per quad	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Crowns	$475	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Bridges	$435	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Full dentures	$535	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Partial dentures resin base	$420	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Inlays	$330	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Onlays	$475	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Simple extractions	$50	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Additional extraction	$50	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Surgical extractions	$105	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Root canal therapy				
Anterior	$300	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Bicuspid	$355	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Molar	$490	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Repairs to prosthetics	$80	30% of PDP fees**		
ORTHODONTIA (Type D) Amount	$2,100***	50% of PDP fees** $1500/person	50% of PDP fees* $1500/person	50% of PDP fees** $1500/person

† South Florida (Area 3) consists of zip codes that begin with the digits 330, 331, 333, 334, 339, 340, 349, 320-329, 335-338, 341-348. If you do not reside in a zip code that begins with these digits, please contact MetLife at 1-800-942-0854 for a more accurate in-network schedule of benefits and fees.

* In-Network: Member pays balance of PDP fees, after plan pays.

** Out-of-Network: Member pays balance of PDP fees, in addition to the remaining balance of claim. Balance equals the difference between total claim and PDP fee.

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA.
See Page 58 for a partial list of eligible expenses or visit FBMC's Web site at www.myFBMC.com for the full version of eligible expenses.

MetLife Indemnity Dental Plan

Your Rates are listed below.

MetLife Dental Plan Rates (per pay period)

Standard Indemnity	10-MONTH	11-MONTH	12-MONTH
Employee	$9.97	$8.31	$7.67
Employee & Family	$30.59	$25.49	$23.53

High Indemnity	10-MONTH	11-MONTH	12-MONTH
Employee	$20.83	$17.36	$16.02
Employee & Family	$62.27	$51.90	$47.90

Limitations

Type A (Preventive & Diagnostic)

- Two oral exams per calendar year
- One fluoride treatment per calendar year up to age 19
- Two cleanings (oral prophylaxis) per calendar year
- Full mouth and panorex X-rays: once per 36 months
- Bitewing X-rays: twice per calendar year for adults; twice per calendar year for children

Type B (Operative & Restorative)

- Space maintainers for premature loss of primary teeth for dependent children to age 19
- Sealants: limitation of one appliance of sealant material for each non-restored permanent first and second molar tooth of a dependent child to age 19, once every 60 months
- Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year, less number of teeth cleanings received during such 12-month period.

Type C (Prosthodontics)

- Relines and rebases to dentures are limited to one per 36 months (minimum is six months after initial installation)
- Adjustment of dentures (minimum is six months after initial installation)
- Consultations are limited to two times per year
- Periodontal scaling and root planning, but not more than once per quadrant in any 24-month period
- Periodontal surgery, including gingivectomy or gingivoplasty, gingival curettage, osseous surgery, bone replacement graft and guided tissue regeneration once per quadrant every 36 months
- Root canal treatment is limited to once per tooth in a 24-month period
- Initial installation of fixed bridgework
- Initial installation of partial or full removable dentures
- Denture replacement: 10 years
- Initial installation of crowns, inlays and onlays
- Immediate denture replacement: 12 months
- Crown replacement: five years

Type D (Orthodontics)

- Benefit for initial preparation, work up and installation of Orthodontic appliances is 20 percent of the total covered expense
- All dental procedures performed in connection with Orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis (quarterly installments)
- Benefits end at cancellation

Exclusions

- Temporomandibular joint disorder (TMJ)
- Implantology
- Services or supplies received before dental expense benefits start for that person
- Services not performed by a dentist except for those of a licensed dental hygienist for scaling and polishing of teeth, fluoride treatment
- Cosmetic surgery, treatment of supplies, unless required for the treatment or correction of a congenital defect of a newborn dependent child
- Replacement of a lost, missing or stolen crown, bridge or denture
- Services or supplies covered by any workers' compensation laws or occupational disease laws
- Services or supplies which are covered by any employers' liability laws
- Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's employer
- Repair or replacement of an orthodontic appliance
- Services or supplies for which no charge would have been made in the absence of dental expense benefits
- Services or supplies for which a covered person is not required to pay
- Services or supplies which are deemed experimental in terms of generally accepted dental standards
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace
- Adjustment of a denture or a bridgework which is made within six months after installation by the same dentist who installed it

Continuation of Exclusions

- Any duplicate appliance or prosthetic device
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride provided in a dental office
- Instruction for oral care such as hygiene or diet
- Periodontal splinting
- Temporary or provisional restorations
- Temporary or provisional appliances
- Services or supplies to the extent that benefits are otherwise provided under the plan or under any other plan which the employer contributes to or sponsors
- Appliances or treatment for bruxism (grinding teeth) including, but not limited to, occlusal guards and night guards
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before dental expense benefits started or as a replacement for congenitally missing natural teeth
- Charges for broken appointments
- Charges by the dentist for completing dental forms
- Sterilization supplies or charges
- Services or supplies furnished by a family member

How to select the MetLife Dental Plans

Employee-Paid Benefits:

1. You may cover yourself by selecting the "Employee Only" benefit.
2. You may cover yourself and your eligible dependent(s) by selecting the "Employee and Family" benefit.

NOTE: If you choose dependent dental coverage, your dependents must be covered by the same dental plan and level of coverage (Standard or High) which you selected for yourself.

About the MetLife Dental Plans

Pre-determination of benefits:

Pre-determination of benefits should be requested for a program of treatment which the dentist estimates will be more than $200. This provision does not apply to charges for emergency treatment.

To access the provider directory, log on to www.dadeschools.net or you may contact the provider at 800-942-0854.

How does the MetLife Preferred Dentist Program (PDP) work?

Dentists who participate in MetLife's Preferred Dentist Program (PDP) have agreed to accept a schedule of maximum fees for services rendered. These scheduled fees are below the average Reasonable & Customary charge. Additionally, dentists agree not to charge for the oral examination during periodic checkups other than the initial exam under the program. **At the point of service, you decide whether to use a dentist in the PDP or any other dentist. Your out-of-pocket costs are less when services are rendered by a participating dentist.**

How do I know if a dentist is in the MetLife Preferred Dentist Program (PDP)?

Visit **www.metlife.com/mybenefits** for a PDP listing of the participating dentists in the South Florida area. To find a participating dentist in your area, call 1-800-474-PDP1 (7371), Monday-Friday, 6 a.m-11 p.m. (ET), and Saturday, 7 a.m. – 4 p.m. (ET). Input the information as requested and a customized PDP directory will be mailed to you.

How can I make an appointment with my dentist?

You may schedule appointments by calling a dentist with MetLife's Preferred Dentist Program (PDP) or any other licensed dentist you choose on or after your effective date of coverage. When you arrive at your dental office, notify them that you have insurance benefits through Metropolitan Life Insurance Company. It will be necessary to use claim forms in order to receive reimbursement.

IN-NETWORK (PDP)

Preferred Dentist's Fee	$62.60
Plan pays 80% of PDP Fee	— $50.08
You pay 20% of PDP Fee	**$12.52**
Your Cost	**$12.52***

OUT-OF-NETWORK

Dentist's Fee	$190.00
PDP Fee	$62.60
Plan pays 80% of PDP Fee	— $50.08
You pay 20% of PDP Fee	**$ 12.52**
charge over Dentist Fee	**$ 127.40**
Your cost	**$139.92****

This example indicates your savings using the MetLife High Dental Plan (Filling-Type B service):

Total $$$ saved by using a MetLife Preferred Dentist = $127.40

* Example assumes $50 deductible has been satisfied.

** Example assumes $150 deductible has been satisfied.

Plan Provider: Metropolitan Life Insurance Company.

Where can I get MetLife Dental Plan claim forms?

Dental claim forms will be provided to you upon request at the Office of Risk and Benefits Management. For claims assistance or status, log on to **www.metlife.com/mybenefits** or call MetLife's Customer Service at 1-800-942-0854.

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to Metropolitan Life Insurance Company Customer Service at 1-800-942-0854.

Who is an eligible dependent for this coverage?

Eligible dependents for this plan include:

- Spouse/Domestic Partner
- Unmarried natural children, adopted children, and stepchildren to the end of the calendar year they reach age 26
- Children older than age 26 will remain covered under this plan only if proof is submitted that he/she suffers from a physical handicap or mental retardation, provided the child remains chiefly dependent upon you for support.
- Children of a Domestic Partner, as long as the Domestic Partner is also covered.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under “Important Phone Numbers.”

Plan Provider: Metropolitan Life Insurance Company.

Vision Plan

The UnitedHealthcare Vision Plan provides access to both private practice and retail chain providers that provide quality eye care and materials. This plan is designed to provide regular eye examinations and benefits toward vision care expenses including glasses or contact lenses.

The Plan offers in-network and out-of-network benefits. When using a participating network provider, you pay a modest co-payment for exam and materials as shown in the Schedule of Benefits. The out-of-network benefit allows you to select any licensed non-network provider. As the plan participant, when visiting a non-network provider, you pay the full fee to the provider and UnitedHealthcare Vision will reimburse you for services rendered up to the maximum allowance. There are no co-pays or deductibles when using an out-of-network provider.

As part of your package you are entitled to receive frames. Frames are covered in full if services are rendered in-network after paying a $10 co-payment and if selecting frames with a $50 wholesale price or less. For out-of-network, we will reimburse up to $45. The in-network contact lens benefit is covered in full after paying a $10 co-payment which includes the fitting/evaluation feeds and up to two follow up visits for covered contacts. For non-covered contacts, there is a $105 allowance applied toward the fitting/evaluation fees and purchase of the contacts. Under the out-of-network contact lens benefit, we will reimburse up to $105 less any fitting/evaluation fee.

Schedule of Benefits

COVERED SERVICES*	IN-NETWORK	OUT-OF-NETWORK
One-Time Co-Payment (Applies to frames and/or lenses, contact lens fitting and follow up)	$10	N/A
Vision Exam (once every 12 months)	Paid in full	up to $40
Single Lenses (once every 12 months)	Paid in full**	up to $40
Bifocal Lenses (once every 12 months)	Paid in full**	up to $60
Trifocal Lenses (once every 12 months)	Paid in full**	up to $80
Frames	Paid in full Private Practice: 100% coverage after $10 co-pay ($50 wholesale allowance) Retail Chain: 100% coverage after $10 co-pay ($130 retail allowance)	up to $45
Frequency	one a year	one a year
Contact lenses (in lieu of frames and lenses)		
Elected by Insured	Paid in full or up to $105 allowance	up to $105
Medically Necessary	Paid in full or up to $175 allowance	up to $175
Mail Order Contact Replacement	10% provider discount	

OPTIONAL SERVICES AT ADDITIONAL COSTS (for Panel Plan only)

	You Pay
Solid Tint	$13
Gradient Tint	$15
Ultra Violet Coating	$23
Scratch Resistance Coating	$0
Anti-Reflection Coating	$40
Glass PGX	
Single Vision	$32
Multifocal	$47

* During any plan year, you may elect either the frames and/or lenses covered service or the contact lenses allowance, but not both.
** Single vision, lined bifocal or lined trifocal are paid in full.

Notes on the UnitedHealthcare Vision In-Network:

1. The eye exam, contact lenses (new or replacement), and lenses are provided once every plan year regardless of prescription change. Frames are provided once a year.
2. Your out-of-pocket cost for the service rendered is paid by you upon receipt of services. Oversize lenses, tinted lenses, sunglasses, and nonstandard and photochromatic lenses may be purchased with an additional charge. Contact lenses are in lieu of frames and lenses.
3. There is no annual deductible with this plan.

How to use the UnitedHealthcare Vision In-Network Plan Benefits:

Using a Panel Eye Doctor

1. A list of participating optometrists and ophthalmologists can be accessed through **www.dadeschools.net**.Benefits listed are valid at all participating eye doctors.
2. Identification cards are not needed. Your eligibility for service is verified by identifying yourself as a UnitedHealthcare Vision Plan participant when you make an appointment with a participating eye doctor.
3. The eye doctor's office will handle all claim forms.

Notes on the UnitedHealthcare Vision Out-of-Network Plan:

1. You are responsible for payment of the entire fee. There will be a one-time reimbursement by the UnitedHealthcare Vision Plan up to the amounts listed on the previous page.
2. The vision exam is provided once every plan year, with a maximum $40 reimbursement.
3. Lenses are provided once every 12 months, if needed, as determined by your optometrist or ophthalmologist.
4. Frames are provided every 12 months, if needed. Frames are limited to a maximum $45 benefit.
5. Contact lenses will be provided once every 12 months under the plan, if needed, as determined by your optometrist or ophthalmologist. Payment will be made for only one pair of lenses, either single, bifocal, trifocal, or contacts during a plan year. No frame or lens benefits are available during the plan year that contact lenses are elected.

How to use UnitedHealthcare Vision Out-of-Network Benefits:

1. UnitedHealthcare Vision Out-of-Network vision benefits are valid at any non-panel licensed ophthalmologist, optometrist or optician.
2. Vision claim forms will be provided upon request by UnitedHealthcare Vision at 1-800-638-3120.

Can you explain the UnitedHealthcare Vision Plan frame benefits?

UnitedHealthcare Vision's generous in-network frame benefit applies to virtually all of the frames on the market today and most of those are covered in-full when visiting a participating network provider, with no additional cost to you other than applicable co-pays. The in-network benefit for both private practice and retail chains are as follows:

Private Practice providers - With UnitedHealthcare Vision's network frame benefit, all frames with a $50 wholesale cost or less are covered in-full (after applicable co-apy). For any frame with wholesale cost greater than $50, you only pay the difference between the wholesale cost of the frame and the $50 allowance.

Retail Chain providers - You receive a $130 retail frame allowance at network retail chain locations. You can expect to receive an equivalent value to what you enjoy at private practice providers. Plus, again for any frame with a retail cost greater than $130, the member only pays the difference between the retail cost of the frame and the $130 allowance.

For out-of-network we reimburse up to $45.

What services and materials does the plan exclude?

- Cosmetic contact lenses.
- Medical or surgical treatment of the eyes.
- Services and materials for orthoptics or vision training, subnormal vision aids, aniseikonic lenses, two pair of glasses in lieu of bifocals, and nonprescription glasses.
- Lost or broken lens replacement or repair, unless it is time for your annual exam.
- Any services and material that Workers' Compensation, another plan or a government agency provides.
- Any employer-required exam as a condition for employment.

UnitedHealthcare Vision Plan

	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
Employee	$3.46	$2.88	$2.66
Employee & Family	$8.64	$7.20	$6.65

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA. Refer to Page 58 for more details. **Visit www.myFBMC.com for a full list of eligible expenses.**

Who is an eligible dependent for this coverage?

Eligible dependents covered under this plan include:

- Spouse/Domestic Partner
- Unmarried children under age 19
- Children (including children of a Domestic Partner, as long as the Domestic Partner is also covered) will be covered under this plan until the end of the calendar year in which he/she reaches age 26 provided the child is a full-time or part-time student or is residing in an eligible employee's home. Coverage for eligible children will also be extended beyond age 19 if the child is incapable of self-care due to a mental or physical handicap and is predominantly dependent upon the covered employee for support and maintenance.

How to select UnitedHealthcare Vision Plan benefits:

1. You may cover yourself by selecting the “Employee Only” benefit.
2. You may cover yourself and your eligible dependent(s) by selecting the "Employee and Family" benefit.

Plan Provider:

This product is offered by UnitedHealthcare Vision, through its parent company, UnitedHealthcare Insurance Company.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

To access the provider directory, log on to www.dadeschools.net or you may contact UnitedHealthcare at 1-800-638-3120.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under “Important Phone Numbers.”

Eighty percent of identity theft has nothing to do with credit. Enlist the comprehensive services of ID Watchdog and you'll be covered from every angle.

What is identity theft?

Identity theft, also known as "identity fraud" is generally defined as the fraudulent use of someone else's information without permission. This means that a victim of identity theft is left with the consequences of his or her imposter's actions, whether he or she is aware of it or not. These crimes can threaten everything from your finances and personal reputation, to your livelihood and physical health.

How We Protect You

Most identity monitoring companies only monitor your information for credit card fraud, but ID Watchdog provides protection for your entire identity. We constantly monitor thousands of databases, watching for suspicious changes in our customers' information, and promise 100% resolution if there is ever a problem on our watch.

Monitoring

When you sign up for ID Watchdog Plus, we will verify your identity and create an Identity Profile Report for you. Each month thereafter, we'll send you an update that highlights any changes or gives you an "all clear" notice.

Step 1 - Verification

Before we unleash our search engines to retrieve your personal information, we utilize an identity verification system that generates personalized questions about you, to ensure that we are providing services to the correct individual.

Verification is the first step in making sure your identity is safe under our watch, and that your information is not being provided to anyone but you.

Step 2 - Identity Profile Report Page

After enrolling in ID Watchdog's services, we'll compile an "Identity Profile Report," containing all of your personal data. This will include all of the addresses and names associated with your identity. Although there may be variances in spelling and data entry errors, we'll have you look for red flags such as completely different addresses or entirely new names, which may be a sign that criminals may be taking advantage of your identity.

If all is recognized and approved by you, we will use this report to check against any new or changed data on a monthly basis, and alert you to any changes. If anything suspicious turns up in your Identity Profile, we'll proceed with an ID SnapShot to start rectifying the problem.

Step 3 - Monthly Monitoring

After your recognized profile has been established, we will comb our thousands of databases for your identity information each month. If there are no new or changed data points, we'll notify you that your records are clean. However, if we find new data points, we will notify you of the changes for you to review. More often than not, the new information will have resulted from a new account you opened. In that case, you can approve the data, and we'll add it to your identity profile.

In the case that the new data is unfamiliar and suspicious, we ask that you let us know. We will initiate extensive reporting that will tell us more about activities on your records through our ID SnapShot, and then proceed with our ID Rehab resolution services, if necessary, until the problem is resolved.

Detection

If there is a reason to believe that your identity has been compromised, be it an unrecognized record in your Identity Profile Report or a suspicious change found through your monthly search, we'll compile an ID Snapshot. The SnapShot is a extensive report that will allow us to pinpoint any fraudulent data. The ID SnapShot pulls information associated with your identity, including addresses, phone numbers, property deeds, driving records, banking accounts, credit history and more. If we detect new threats after your enrollment in ID Watchdog Plus, your ID Snapshot is included in your plan, but it can also be purchased separately for any pre-existing conditions.

The ID SnapShot pulls information associated with your identity, including the following:

Credit Reports
DMV Driving History
Motor Vehicle Registration History
Global Criminal Check
U.S. Criminal Record Check
U.S. Wants and Warrants Check
Sex Offender Registry
Social Security Number Trace
Terrorist Watch List
Bankruptcies, Liens and Judgments
And much more...

If you require an ID SnapShot, we'll be compiling a very detailed report with highly-sensitive data, so we'll just need a few additional components from you to verify our permission to pull these records on your behalf. We'll work with you to obtain these documents, so that we can efficiently compile and mail your full report to your home.

After providing the ID SnapShot to you and going over any unfamiliar data, we will then decide whether our ID Rehab resolution services are required. Through the ID SnapShot, we will know exactly which entities to contact in order to clear your good name.

Resolution

Should your ID SnapShot reveal any indication that you have been a victim of identity theft, we will work on your behalf to clear your name through our unique ID Rehab™ process. Our resolution experts will negotiate with any applicable institutions, file the necessary paperwork, and follow up to see that your good name is restored. This restoration is provided, free of charge, to ID Watchdog Plus

customers who encounter issues while enrolled in the program, and is backed by our 100% resolution guarantee. ID Watchdog ensures you'll never have to worry about cleaning up the damage that can come from a breached identity.

This service, which is free of charge to any customers who become victimized during their enrollment in ID Watchdog Plus, will include the work it takes to clear your good name. After obtaining a police report and ID Theft Affidavit as proof that damages have occurred, our Resolution Agents will use limited Power of Attorney to work towards restoring the identity that is rightfully yours. By communicating on your behalf with the agencies that control your records, our experts will do all of the legwork for you.

Our guarantee of full-service protection means that we won't stop until you are no longer held responsible for any damage caused by the identity thief.

ID Rehab is included, at no extra cost, for ID Watchdog customers who become a victim while enrolled in our services, but can also be purchased separately to help you resolve any pre-existing instance of identity theft.

You could spend hundreds of hours rectifying a case of stolen identity, but with the ID Rehab services of ID Watchdog your identity will be secure again before you know it.

Take Control with Online Account Access

You can manage your account online with our exclusive Identity Management Dashboard and receive alerts and communication via e-mail. This 24/7 access allows you to check your Identity Profile Report at your leisure, and make updates to your data at any time. Through our secure web site, you'll have the option to make the most of your ID Watchdog monitoring by providing more insight into the records that are associated with your identity. Also, by managing your account exclusively online, you'll save precious time by receiving your monthly alerts instantly to your inbox.

If you need additional support, you can call us with your questions at 1-800-970-5182. Our Customer Service is available: Monday - Friday 8 a.m. - 6 p.m. (MST).

Who is an eligible dependent covered under this plan?

Eligible dependents covered under the this plan include:

- Spouse (until a final decree of divorced has been filed)
- Domestic Partner
- Unmarried natural children, stepchildren, children under your care through court-approved guardianship, and children of a Domestic Partner through the end of the calendar year in which he/she reaches age 20.
- Children may be covered until the end of the calendar year in which the child reaches age 25 if he/she is a full-time or part-time student who receives more than half of his/her financial support from the eligible employee. Children may also be covered until the end of the calendar year in which he/she reaches age 25 if the child suffers from a mental or physical handicap, is incapable of self-support, and is fully dependent upon the employee for support.

Your individual plan rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
ID Theft Plan (Employee only)	$ 4.77	$ 3.98	$ 3.67
ID Theft Plan (Family)	$8.97	$7.48	$6.90

What is ID Watchdog?

ID Watchdog was created in 2004 by a group of seasoned credit professionals who recognized the growing crime of identity theft and sought out to provide un-matched protection services to consumers. By enlisting experts on all facets of identity theft – including law enforcement authorities, judicial representatives, consumer privacy advocates and banking and credit experts – ID Watchdog created the most powerful, pro-consumer identity theft protection product possible. ID Watchdog is a publicly traded company on the Toronto Stock Exchange, under the symbol (IDW.V.)

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

Legal Plan Coverage

Administered by ARAG, the legal plan is a legal safety net that provides **comprehensive** legal protection and resources. The legal plan includes:

- No waiting periods on ANY coverages (including bankruptcy and divorce). You can use the plan as soon as you need it.
- Broad coverage of life's legal issues. More coverages for your investment including defense of motions to modify, administrative hearings and IRS audit protection and collection defense.
- Freedom of choice for representation. You can choose ANY attorney you want to work with, in or outside ARAG's Network. ARAG doesn't assign attorneys for representation.
- A trusted carrier with national reach. As a leading provider of legal insurance in the United States for more that 35 years, you have access to ARAG's its nationwide network of more than 6,600 attorneys.

You can use the ARAG Legal Plan as soon as you need to, NO waiting periods. Benefits include:

In-office Legal Representation

Attorney fees for most covered matters are 100% paid-in-full when you work with your choice of a Network Attorney with NO waiting periods unless otherwise stated. Network Attorneys provide legal representation – including review and document preparation – for covered legal matters including:

- Standard Will Preparation
- Complex Will Preparation (up to 6 office hours)
- Codicil Preparation (Amendment to a Will)
- Living Will Preparation
- Powers of Attorney Preparation
- Contested Guardianship/Conservatorship• Uncontested Guardianship/Conservatorship
- Legal Name Change Proceedings
- Contested Divorce (up to 10 office Hours/$70 per hour for all additional hours)
- Uncontested Divorce
- Defense of Motions to Modify, a Final Divorce Decree
- Spousal Divorce *(partial reimbursement)*
- Consumer Protection
- Debt Collection Defense
- Juvenile Court Proceedings
- Defense of Felony *(name insured only)*
- Criminal Misdemeanor Defense
- Driving Privilege Protection
- Driving While Intoxicated
- Personal Transfers *(1 purchase and sale per year)*
- Refinance *(up to 1 hour per year)*
- Personal Property Issues
- Tenant Rental Issues
- Administrative Hearings *(includes visa extensions, naturalization and deportation, also referred to as removal)*
- Insanity and Infirmity Defense
- IRS Audit Protection *(partial reimbursement)*
- IRS Collection Defense *(partial reimbursement)*
- Personal Bankruptcy
- General In-Office for any other legal issues - *(up to 2 hours per family every 6 months)*

For a complete list, please review the chart on Page 91.

To locate a Network Attorney in your area, call the toll-free number, 800-360-5567, or visit **10287mds, click on the "Choose Your Plan" tab and the Attorney Finder link.**

You can see a Network Attorney for legal representation – including review and document preparation.

You may also select a Non-Network Attorney and the plan will reimburse you according to scheduled limits. The legal services that are available are listed on the chart on Page 91.

Reduced Fee Services

If you need legal representation for a legal situation that's not covered under the ARAG Legal Plan, you can still save money through the Reduced Fee Benefit. Network Attorneys provide a reduced fee of at least 25 percent off their normal hourly rate for any legal situations that are not covered or excluded.

Telephone Legal Advice and Consultation

Attorneys can easily handle certain legal matters over the phone. You can consult with a Network Attorney over the phone as often as necessary – for any of the following legal needs, including:

- General Legal Advice and Consultation on virtually any legal matter
- Standard Will Preparation
- Living Will Preparation
- Durable Powers of Attorney Preparation
- Small Claims Assistance
- Follow-up Calls and Letters
- Specific Document Preparation
- Document Review

Identity Theft Services

You have toll-free access to Certified Identity Theft Case Managers who will help you get your life back in order and repair any damage done to your identity, The case managers will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain plan coverages that may be relevant to the identity theft, such as Consumer Protection
- Provide Identity Theft Prevention and Victim Action Kits
- Monitor the resolution of the situation

Immigration Assistance

To help with the immigration process, your plan includes:

- Toll-free telephone advice from an attorney on how immigration relates to your legal matter and what actions may be taken.
- Access to immigration education materials.
- Access to Network Attorneys who will provide reduced fee services of at least 25% off their normal hourly rate for specific covered matters.

Online Legal Tools and Resources

The ARAG Legal Center provides easy online access to legal tools and resources, including:

- Assessments, calculators, and profiles to learn what legal matters may impact your life.
- An Education Center offering a wide range of tools to educate and empower you to handle your legal issues, including the Law Guide, Guidebooks, LawExpresso and the Legal Glossary.
- Hundreds of Do-It-Yourself Legal Documents™, when you want the convenience and control of preparing legally valid documents yourself.

Financial Education and Counseling Services - ARAG Exclusive

You have access to PricewaterhouseCoopers LLP professional Financial Counselors and an online resources exclusively through your ARAG Legal Plan. Experienced Financial Counselors are available to answer questions and provide guidance on a range of financial topics including:

- General Financial Planning Information and Guidance
- Cash and Debt Management/Budgeting
- Retirement and Investment Planning
- Federal Tax Information and Education
- Individual Retirement Accounts (IRAs)

You also have access to an online resources through the ARAG Legal Center that provide:

- A Personalized Financial Plan
- A Step-by-Step Action Plan
- Life Events Guides and Financial Articles
- Online Courses
- Financial Calculators
- A Mutual Center
- Webcasts

Your rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
Legal Plan	$ 10.38	$ 8.65	$ 7.98

What if I have a legal concern that existed before I became insured under the ARAG Legal Plan?

Coverage for pre-existing matters is included as long as the legal action or charge is filed and the attorney is first retained after the effective date of the policy. (Most attorneys' fees are 100 percent paid-in-full for covered matters when a Network Attorney is used.) Coverage is provided for matters in process at the time of termination of employment or plan termination. Coverage is provided anywhere in the United States.

How to Use Legal Benefits

You can use your ARAG Legal Plan as soon as you need to, with NO waiting periods, in the following ways:

1. **Legal Advice and Consultation:** Insured employees can reach a Network Attorney by calling 800-360-5567, Monday - Friday, 8 a.m. - 8 p.m., ET.
2. **Legal Representation Services – Network Attorney:** Contact the Network Attorney of your choice and identify yourself as an insured M-DCPS employee and ARAG member. The Network Attorney will file a claim with ARAG to receive reimbursement and, for most covered benefits, attorney fees are 100 percent paid-in-full. You will be responsible for any filing fees, court costs and miscellaneous costs, such as photocopying.
3. **Legal Representation Services – Non-Network Attorney/Indemnity Coverage:** You may choose to use an attorney not in the network and be reimbursed by ARAG up to schedule maximums by submitting a claim form and your attorney's billing statement directly to ARAG. Claim forms can be obtained by calling the ARAG Customer Care Center at 800-360-5567, Monday - Friday, 8 a.m. - 8 p.m. p.m., ET or by logging in as a member at ARAGLegalCenter.com and clicking on the "Find an Attorney" tab and the "Non-Network Attorney Claim Form" link.

How to Select ARAG Legal Benefits

You may cover yourself and your family by selecting the ARAG Legal Plan under the Employee-Paid FlexPlan Benefits section of the online enrollment.

How does the legal coverage benefit affect taxes?

According to IRS rules, the Legal Plan is not qualified to be included in the FlexPlan as a tax-free benefit. If you select legal coverage, your premium is deducted on an after-tax basis (POST-TAX).

What legal services does the plan exclude?

Plan exclusions include: actions between you and your employer, union, fellow employees, Fringe Benefits Management Company, insurance carriers, ARAG Insurance Company, or anyone else when prohibited by law; business matters, preparation of tax returns, patents or copyrights, summary procedure actions; class actions, interventions or amicus curiae filings, citizen's dispute settlements program procedures; filing fees, court costs, and miscellaneous costs, or matters where other reimbursement is available; contingency fee, workers' compensation, unemployment compensation and probate cases; actions between you and your dependents; duplication of services previously claimed, title search and title insurance, and legal proceedings where you are entitled to legal representation or reimbursement from any other source; and matters related to structural damage to dwellings, appurtenances, paved surfaces and matters not specifically listed.

Who is an eligible dependent covered under this plan?

Eligible dependents covered under the Legal Plan include:

- Spouse (until a final decree of divorced has been filed)
- Domestic Partner
- Unmarried natural children, stepchildren, children under your care through court-approved guardianship, and children of a Domestic Partner through the end of the calendar year in which he/she reaches age 19.
- Children may be covered until the end of the calendar year in which the child reaches age 25 if he/she is a full-time or part-time student who receives more than half of his/her financial support from the eligible employee. Children may also be covered until the end of the calendar year in which he/she reaches age 25 if the child suffers from a mental or physical handicap, is incapable of self-support, and is fully dependent upon the employee for support.

Which insurance company makes the Legal Plan available to me?

ARAG Insurance Company underwrites and administers the plan. A.M. Best's Reports, an organization that compares and rates the financial strength and performance of insurance companies, rates ARAG Insurance Company "A" (Excellent).

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Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

What legal services are available?

The chart below shows the legal services available.

COVERAGE	Network Attorney	Non-Network Attorney*
In-Office Legal Services		
Consumer protection	Paid in full	$2,200**
Debt Collection Defense		
IRS audit protection		
(attorney or accountant)		
Audit consultation	$420*	$420*
Representation at audit before litigation	$900*	$900*
Defense for IRS litigation	$5,000*	$5,000*
Personal bankruptcy/wage-earner plan	Paid in full	$420*
Dissolution		
Divorce, legal separation or annulment (coverage for employee)		
Uncontested	Paid in full	$600*
Contested		$600*
	ARAG will pay a Network Attorney in full for the first 10 hours of the attorney's time. The Network Attorney will bill the insured at $70 per hour for all additional hours.	
Employee's Spouse's legal fees	$300*	$300*
Defense of motion to modify a prior divorce decree	Paid in full	$360*
Adoption	Paid in full	$350*
Contested Guardianship/Conservatorship		
Uncontested Guardianship/Conservatorship	Paid in full	$300*
Incompetency or infirmary proceedings	Paid in full	$2,200**
Name change	Paid in full	$240*
Juvenile court proceedings (excluding traffic matters)	Paid in full	$2,080**
Habeas corpus	Paid in full	$300*
Defense of DWI	Paid in full	$2,080**
Criminal misdemeanor defense (except involving motorized vehicles)	Paid in full	$2,080**
Traffic charges where your license could be suspended or revoked	Paid in full	$2,080**
Felony (named insured only)	Paid in full	$2,500*
Estate planning		
Individual simple will	Paid in full	$100
Husband and wife simple wills	Paid in full	$125
Codicil	Paid in full	$60*
Complex Wills (Wills with trust)	Paid in full 6 hrs.	$240*
Living will	Paid in full	$60*
Durable power of attorney	Paid in full	$60*
Purchase/sale of principal residence (one attempt at each per year)	Paid in full	$360*
Real estate refinancing (limit of one hour)	Paid in full	$60*
Administrative hearings (excluding employment related)	Paid in full	$1,200*
General In-office***		
Office consultations for legal advice, negotiation, document preparation and review	2 hours every 6 months per family, noncumulative***	$120*
Telephone Legal Advice and Consultation	Paid in full	N/A

Attorneys can easily handle certain legal matters over the phone. You can consult with a Network Attorney over the phone as often as necessary – for any of the following legal needs including:

- General Legal Advice and Consultation on virtually any legal matter
- Standard Will Preparation
- Living Will and Durable Powers of Attorney Preparation
- Small Claims Assistance
- Follow-up Calls and Letters
- Specific Document Preparation
- Document Review

COVERAGE CONTINUED	Network Attorney	Non-Network Attorney*
ONLINE LEGAL TOOLS AND RESOURCES – Paid in full	N/A	N/A

At ARAGLegalCenter.com, you have easy online access to legal services, including:

- Assessments, calculators, and profiles to learn what legal matters may impact your life.
- An Education Center offering a wide range of tools to educate and empower you to handle your legal issues, including:
  - Law Guide - easy-to-understand legal articles to help you research your legal situation.
  - Guidebooks - A collection of "go-to guides" with detailed information and checklists to assist you with common life events.
  - Legal Glossary - An easy-to-use glossary to help you better understand complex legal terms.
- A Law Guide of easy-to-understand legal articles to help you research and learn more about your legal situation.
- Hundreds of Do-It-Yourself Legal Documents™, for when you want the convenience and control of preparing legally valid documents yourself.

VALUE-ADDED SERVICES		
• Financial and EducationCounseling Services - Paid in Full	N/A	N/A
• Identity Theft Services - Paid in full	N/A	N/A
• Immigration Assistance - Paid in Full		

* Non-Network Attorney coverage is at $60 per hour to the stated amount for pre-trial; $200 for 1/2 day trial.

** Trial coverage of $1600 is included in these amounts ($200 for half-day trial, and major coverage). Pretrial coverage is the stated amount less $1600.

*** You cannot use the 2 hours to increase any other plan benefits or waive their limitations.

ARAG SeniorAdvocate™ Legal Plan

M-DCPS offers a one-stop resource with the legal, financial and adult care assistance you need to take care of your family: SeniorAdvocate Legal Plan, administered by ARAG.

With SeniorAdvocate, you can receive legal advice and consultation, and reduced fee services on a variety of legal matters including: fraud, schemes and scams, planning for incapacity, healthcare decisions, financial planning, debt and consumer protection and estate planning.

Which of my family members can benefit from the SeniorAdvocate™ Plan?

You can use the plan for matters related to your parents, grandparents, spouse's parents and spouse's grandparents.

What legal services are offered?

Legal Advice and Consultation

You will have toll-free access to a Network Attorney for the following services:

- Legal Advice and Consultation - Toll-free telephone advice on how the law relates to senior family members personal legal matters and which actions may be taken.
- Document Preparation - Assistance with the preparation or review of the following documents as they relate to the senior family members:
  - Special powers of attorney and revocations
  - Challenge to denial of credit
  - Bad check notice
  - Promissory notes and affidavits related to their personal property
  - Bills of sale related to personal property
- Document Review - Attorneys will review legal documents for the senior family member, up to four pages, except those related to trusts or real estate property transfers.
- Follow-up Calls/Correspondence - Assistance with follow-up telephone calls and correspondence to third parties, related to the senior family member.

Legal Representation

If a matter requires an in-office visit, you can meet with a Network Attorney and you are guaranteed at least a reduced fee of at least 25 percent off of his/her normal rates.

To use a Network Attorney:

- Contact the attorney to make an appointment. Identify yourself as an ARAG plan member.
- Ask the attorney what materials you should bring to your appointment.
- The attorney will provide the needed services.
- The Network Attorney will bill you directly at the discounted rate.

What Financial Educational and Counseling Services are available?

Only through ARAG's SeniorAdvocate, you have exclusive access to professional financial counselors from PricewaterhouseCoopers LLP and an interactive financial planning web site to help you deal with your senior family members financial future.

Experienced financial counselors are available to answer questions and provide guidance on a range of financial topics including:

- General Financial Planning Information and Guidance
- Cash and Debt Management/Budgeting
- Retirement and Investment Planning
- Federal Tax Information and Education
- Individual Retirement Accounts (IRAs)

You also have access to an interactive financial planning web site that offers:

- A Personalized Financial Plan
- A Step-by-Step Action Plan
- Life Events Guides and Financial Articles
- Online Courses
- Financial Calculators
- A Mutual Center
- Webcasts

Identity Theft Services

You have toll-free access to Certified Identity Theft Case Managers who will help your senior family members get their life back in order and repair any damage done to their identity. The case managers will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain relevant plan coverages
- Provide Identity Theft Prevention and Victim Action Kits
- Monitor the resolution of the situation

To access the provider directory, visit ARAGLegalCenter.com, enter Access Code: 10287mds, click on the "Choose Your Plan" tab and the Attorney Finder link.

For questions relating to your account, contact a Customer Care Specialist at 800-360-5567, Monday - Friday, between 8 a.m. - 8 p.m. ET.

What are Caregiving Services?

You can receive assistance in planning for your own or your senior family member's immediate or future adult care needs through toll-free, telephone access to a Care Advocate who will:

- Answer your eldercare-related questions, assess eldercare needs and help you develop a care plan.
- Send you a **customized information guide** that contains lists of assisted living facilities, nursing homes or home health care agencies – including comparative quality-of-care ratings and reports on thousands of facilities and agencies – along with helpful eldercare information.
- Give you access to the nation's most comprehensive eldercare database with more than 90,000 long-term care providers.
- Conduct searches to determine availability and rates of assisted living facilities, nursing homes, home health care agencies and adult day care providers. Advocate will negotiate discounts when available.

Plus, you will have access to the **ElderAnswers Website** which provides you online access to quality-of-care ratings and reports, direct access to the provider database, and a wide-range of eldercare information.

Which insurance company makes the SeniorAdvocate Legal Plan available to me?

ARAG Insurance Company underwrites and administers this plan. A.M. Best's Reports, an organization that compares and rates the financial strength and performance of insurance companies, rates ARAG Insurance Company "A"(Excellent).

Visit ARAGLegalCenter.com and enter Access Code: 10287mds for more information.

Life the Way You Want to Live™

For your convenience, attorney information and an online Attorney Finder can be found when you visit ARAGLegalCenter.com, enter Access Code: 10287mds, click on the "Choose Your Plan" tab and the Attorney Finder link. the Customer Care Center at **800-360-5567**, Monday - Friday, 8 a.m. – 8 p.m. ET. The ARAG Network Attorneys average nearly 25 years of experience.

Is your personal attorney a member of the ARAG Attorney Network? If not, let them know and they can contact ARAG about joining, or the attorney can visit **www.ARAGgroup.com**.

Your rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
SeniorAdvocate™ Program	$4.66	$3.88	$3.58

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

Legal Plan Coverage

The Family Protector covers employees and their dependents and provides legal services from Network and Non-Network Attorneys.

In-Office Legal Representation

Most of the following benefits are 100% paid-in-full for attorneys' fees when you use a Network Attorney.

- Simple Will
- Complex Will
- Codicil
- Living Will
- Power of Attorney
- Guardianship/Conservatorship
- Name Change
- Divorce
- Child Support
- Post Judgment Decree
- Post Decree Modification
- Consumer Protection
- Consumer Debt Collection
- Juvenile Proceedings
- Criminal Misdemeanor
- Immigration
- Driving Privilege Protection
- Personal Property Issues
- Tenant Rental Issues
- IRS Audit Protection
- IRS Collection Defense
- Real Estate
- Estate Administration
- Expungements

To locate a Network Attorney in your area, call the toll-free telephone number 800-356-LAWS or visit: **www.uslprotects.com/members/family-protector/mdcps**

You can see a local Network Attorney for legal representation – including review and document preparation.

You may select a Non-Network Attorney and the plan will reimburse you according to scheduled limits. The legal services available are listed on the chart on Page 97.

Reduced Fee Services

If you need legal representation for a legal situation that's not covered under The Family Protector, but not specifically excluded, you can still save money by using a Network Attorney at a reduced fee of at least 33 1/3% percent off their normal hourly rate for legal matters.

Telephone Legal Advice

Attorneys can easily handle certain issues over the phone. You can consult with a Network Attorney over the phone as often as necessary for virtually any personal legal need, including:

- General Legal Advice
- Will Preparation
- Living Will Preparation
- Durable Powers of Attorney Preparation
- Small Claims Assistance
- Follow-up calls and letters
- Specific Document Preparation
- Document Review

Immigration Coverage

- Visa Extensions: Defined as application for extension of any existing visas where eligible for said extensions.
- Naturalization: Defined as advice, consultation, preparation and filing of applications for naturalization before the United States Bureau of Citizenship and Immigration Services.
- Deportation (Now known as Removal): Advice, consultation and appearance before the U.S. Immigration Court to provide members with Defense of Removal actions and/or applications for Relief from Removal before the Immigration Judge.

Legal Tools and Resources

You have easy online access to legal services, including:

- An extensive law guide of articles on everyday legal topics
- Do-it-yourself personal legal documents
- Attorney Locator
- Other education information

Identity Theft Services

As a member, you have access to a highly trained Fraud Resolution Specialist who will conduct seven emergency response activities, including:

- Assisting members with restoring their identity and good credit
- Provide members with a free "ID Theft Emergency Response Kit"
- Assists with disputes of fraudulent debts, as a result of ID theft
- Counsels and provides a document stating the "Preventative Steps" to avoid future ID theft losses and damages

Personal Financial and Tax Planning Services

The financial coaching benefit provides access to "Financial Coaches" with a broad range of experience in financial services, including licensed CPA's and Certified Financial Planners. Our Coaches are salaried professionals who do not sell or promote products and services to our members. The financial benefit allows families an opportunity to determine the most appropriate way to handle their financial problems or issues by talking with an expert.

What about legal matters that occurred before I became insured under the U.S. Legal Plan?

Coverage for pre-existing matters is included as long as the legal action is filed and the attorney is first retained after the effective date of the policy. (Most attorneys'fees are paid-in-full for covered matters when a Network Attorney is used.) Coverage is provided for matters in process at the time of termination of employment or plan termination. Coverage is provided anywhere in the United States. Further required legal services may be obtained for a 1/3 discount.

How to Use Legal Benefits

1. Legal Advice and Consultation: Insured employees can reach a Telephone Network Attorney by calling 1-800-356-LAWS, 24/7.
2. In-office Legal Representation Services Network Attorney: Contact an attorney and identify yourself as an insured M-DCPS employee and U.S. Legal member. The local Network Attorney will file a claim with U.S. Legal to receive reimbursement and, for most covered benefits, attorney fees are paid-in-full. You will be responsible for any filing fees, court costs and miscellaneous costs.
3. In-office Legal Representation Services Non-Network Attorney/Indemnity Coverage: You may use any non-Network Attorney and be reimbursed by U.S. LEGAL up to schedule maximums by submitting a claim form and your attorney's billing statement directly to U.S. LEGAL. Claim forms can be obtained by calling the FBMC Customer Care Center at 1-800-342-8017, Monday Friday, 7 a.m.- 10 p.m., ET or by logging into the U.S. LEGAL Web site at **www.uslprotects.com/member/familyprotector/mdcps**

How to Select Legal Benefits

You may cover yourself and your family by selecting U.S. Legal under the Employee-Paid FlexPlan Benefits section of the online enrollment.

How does the legal coverage benefit affect taxes?

According to IRS rules, the Legal Plan is not qualified to be included in the FlexPlan as a tax-free benefit. If you select legal coverage, your premium is deducted on an after-tax basis (POST-TAX).

What legal services does the plan exclude?

Actions between you and your employer, union, fellow employees, Fringe Benefits Management Company, insurance carriers, U.S. LEGAL Insurance Company, or anyone else when prohibited by law; business matters, preparation of tax returns, patents or copyrights, summary procedure actions; class actions, interventions or amicus curiae filings, citizen's dispute settlements program procedures; filing fees, court costs, and miscellaneous costs, or matters where other reimbursement is available; contingency fee, workers' compensation, unemployment compensation and probate cases; actions between you and your dependents; duplication of services previously claimed, title search and title insurance, and legal proceedings where you are entitled to legal representation or reimbursement from any other source; and matter related to structural damage to dwellings, appurtenances, paved surfaces and matters not specifically listed.

Your US Legal rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
Family Protector	$10.14	$8.45	$7.80

Who is an eligible dependent covered under this plan?

Eligible dependents covered under the Legal Plan include:

- Spouse (until a final decree of divorced hasbeen filed)
- Domestic Partner
- Unmarried natural children, stepchildren, children under your care through courtapproved guardianship, and children of a Domestic Partner through the end of the calendar year in which he/she reaches age 19.
- Children may be covered until the end of the calendar year in which the child reaches age 25 if he/she is a full-time or part-time student who receives more than half of his/her financial support from the eligible employee. Children may also be covered until the end of the calendar year in which he/she reaches age 25 if the child suffers from a mental or physical handicap, is incapable of self-support, and is fully dependent upon the employee for support.

Which insurance company makes the Legal Plan available to me?

U.S. Legal Services, Inc. underwrites and administers the Family Protector Legal Plan. The Family Protector is recognized nationally by consumer groups as one of the broadest and most comprehensive legal plans in the industry.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

"

What Legal services are available?

The chart below shows the legal services available:

COVERAGE	NETWORK ATTORNEY	NON-NETWORK ATTORNEY*
In-Office Legal Services		
Consumer Protection Action		
Including Small Claims Court	Paid-in-Full	$2,200**
IRS Audit Protection (attorney or accountant)		
Consultation	$420*	$420*
Representation at audit before litigation	$900*	$900*
Defense for IRS litigation	$5,000*	$5,000*
Personal bankruptcy/wage earner plan	Paid-in-Full	$500*
Dissolution		
Divorce, separation or annulment (coverage for employee)		
Uncontested	Paid-in-Full	$600*
Contested	15 hours paid in full per calendar Year, Network Attorney will bill $70 per hour thereafter	$600*
Employee's Spouses legal fees	$300*	$300*
Defense of Post Decree issues	15 hours paid in full per calendar Year, Network Attorney will bill $70 per hour thereafter	$600*
Adoption	Paid-in-Full	$350*
Guardianship/Conservatorship	Paid-in-Full	$300*
Incompetency or infirmary proceedings	Paid-in-Full	$2,200**
Name Change	Paid-in-Full	$250*
Juvenile Court (excluding Traffic)	Paid-in-Full	$2,100*
Habeas Corpus	Paid-in-Full	$300*
Defense of DUI	Paid-in-Full	$2,100**
Criminal Misdemeanor (excluding Traffic)	Paid-in-Full	$2,100**
Traffic charges where your license could be suspended or revoked	Paid-in-Full	$2,100**
Felony (named insured only)	Paid-in-Full	$2,500**
Estate Planning		
Individual Simple Wills	Paid-in-Full	$100
Husband and Wife	Paid-in-Full	$125
Codicil	Paid-in-Full	$60
Wills with Trust	Paid-in-Full	$240
Living Will	Paid-in-Full	$60
Durable Power of Attorney	Paid-in-Full	$60
Purchase sale of primary residence	Paid-in-Full	$360*
Real Estate Refinancing	Paid-in-Full	$60*
Administrative Hearings (excluding employment related)	Paid-in-Full	$1,200*
Preventative Law	Paid-in-Full	$120
Immigration	Paid-in-Full	$420*
Estate Administration	Paid-in-Full	$420*
Business Law	Paid-in-Full	$60
Expungement	Paid-in-Full	$240

US Legal Family Protector

COVERAGE	NETWORK ATTORNEY	NON-NETWORK ATTORNEY*
In-Office Legal Services		
Online Tools and Resources • Law Guide of articles of everyday legal topics • Do-it-yourself personal legal documents • Attorney search • Other educational material	N/A	
Value-Added Services • Financial Planning and Tax Advice Paid-in-Full • Identity Theft Services		

* Non-Network Attorney coverage is $60 per hour to the stated amount for pre-trial; $200 for ½ day trial
** Trial coverage of $1600 is included in these amounts ($200 for one-half day trial and major coverage) Pre-trial is the stated amount less $1600

Senior Protector

Elder Law attorneys will assist you with the many legal and other issues which confront seniors and retirees and parents of our members. Elder law attorneys can advise you on the laws in your state and assist you in all the coverage areas of Part I. Elder Law Attorneys could also be of assistance if your net worth or your asset structure is unusually complex. Your legal plan has contracted with this sector of the bar in anticipation of your specific needs in this area of law.

Which of my family members can benefit from the Senior Protector Plan?

If you are buying the plan to help care for senior family members, you can use the plan for matters related only to your parents, grandparents, spouse's parents and spouse's grandparents.

What legal services are offered?

Legal Advice and Consultation

- Telephone Legal Access Services
- Telephone Legal Assistance with preparation of documents
- Elder Fraud and Schemes
- Planning for Incapacity
- Health Care decisions
- Financial Planning
- Debt and Consumer Counseling
- Estate Planning, Wills, Trusts and Living Trusts
- Medicare and Private Health Insurance
- Medicaid

Legal Representation

If a matter requires an in-office visit, you can meet with a Network Attorney and you are guaranteed a reduced fee of at least 33 1/3% off the attorney's normal hourly rates.

To use a Network Attorney:

- Call into U.S. Legal's toll-free number, 800-356-LAWS, and tell the CSR you need an attorney for a Senior Protector Issue. The CSR will assign you an attorney with experience in the area of your legal issue.
- Contact the attorney to make an appointment. Identify yourself as an U.S. Legal member.
- Ask the attorney what material you should bring to your appointment.
- The attorney will provide the needed services.
- The Network Attorney will bill you directly at the discounted rate.

What Financial Tax Planning Services are available?

With personal financial counseling, members have access to:

- Toll-free, confidential telephone access to an experienced financial planner
- One-on-one counseling – with no sales pitches
- Planners who are familiar with all areas of financial planning
- Assistance in integrating all resources into an overall financial plan
- Personalized reports on topics such as Investment for Retirement, Asset Allocation and College Funding.

Your US Legal rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
Senior Protector	$4.65	$3.88	$3.58

Identity Theft Services

You will have toll-free access to an Identity Theft Case Manager who will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain relevant plan coverage
- Monitor and follow-up on the situation

What are the Independent Living services?

You can receive assistance in planning for your own or your senior family member's immediate or future adult care needs through toll-free, telephone access from Adult Care Specialists. They can assist plan members in matters relating to:

- Nursing homes
- Home health care
- Long distance caregiving
- Emergency and respite care
- Discharge planning
- Residential care
- Housing options
- Senior centers
- Caregiver issues and concerns
- Adult daycare
- Long-term care insurance
- Transportation services
- Medicare and Medicaid
- Social Security
- Community services
- Funeral planning
- Grief and bereavement
- Hospice services
- Meal delivery programs

Adult Care Specialists conduct a comprehensive intake and needs assessment with plan members. Once the specialist has fully assessed your needs, you will be provided with a basic overview of the types of providers and resources available.

Which insurance company makes the Legal Plan available to me?

U.S. Legal Services, Inc. underwrites and administers the Family Protector Legal Plan. The Family Protector is recognized nationally by consumer groups as one of the broadest and most comprehensive legal plans in the industry.

Client Organizer and Checklist

By virtue of becoming a member of this plan you are entitled to receive a Client Organizer and Checklist. This document has been prepared for your use by attorneys who specialize in Elder law and Taxation. The areas of Elder law and Taxation cover a wide variety of issues that older Americans and their children must deal with and will serve as a quick reference by you of the foregoing summary of areas of the law that you are entitled to consult. This Organizer has been designed to achieve maximum efficiency. The Organizer is divided into general areas of law so as to be of its best help to you in evaluating your own circumstances and at the same time readily and efficiently allows you to be able to give to your attorney the information that he or she will need to advise you as best as is possible.

When you receive the Organizer, please familiarize yourself with its contents and make arrangements to keep it permanently secured in a safe place where you would normally keep your other important records. This Organizer is best utilized prior to calling the attorney. When you need to discuss a problem or matter with your attorney, please refer to your Organizer and to the general area of concern that is reflected in the table of contents of the Organizer. Please review the questions therein and be prepared to give those answers to your attorney when you call.

Will & Trust Planner

Your membership in this plan also entitles you at no cost to receive a free Will & Trust Planner. This document has been prepared by our attorneys and will enable you to decide if you need a will or trust, or, whether you need to update or change an existing will or trust.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage. Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under “Important Phone Numbers.”

www.uslprotects.com/members/family-protector/mdcps
800-356-LAWS

Short-Term Disability (STD)

The Miami-Dade County School Board provides all eligible, full-time employees with Standard Short-Term Disability (STD). This Standard STD plan provides a benefit of 60 percent of your earnings up to a maximum of $500 per week. Benefits under this plan are paid up to 22 weeks after a 30 calendar day elimination period. You may elect to upgrade this plan by purchasing one of the upgrade plans available.

What is Short-Term Disability?

STD provides weekly benefits for short periods of disability due to injury or illness, as defined in the policy.

What are my levels of coverage?

You may elect to purchase the High Plan on a voluntary basis.

Standard Upgrade: This plan upgrades your Standard STD plan by paying benefits up to 24 weeks after a 15 calendar day elimination period. It continues to provide 60 percent of your earnings up to a maximum of $500 week.

High: This plan is designed for employees with salaries in excess of $43,000 annually. It provides the same 22 week benefit period after a 30 calendar day elimination period, while providing a benefit of 60 percent of your earnings up to a maximum of $1,000 week.

High Upgrade: This plan is also designed for employees with salaries in excess of $43,000 annually. It provides a 24 week benefit period after a 15 calendar day elimination period, while providing a benefit of 60 percent of your earnings up to a maximum of $1,000 week.

When can I begin collecting benefits?

There are two levels of coverage.

Standard and High Plans - Benefits are paid up to 22 weeks after a 30 calendar day elimination period.

Standard Upgrade and High Upgrade Plans - Benefits are paid up to 24 weeks after a 15 calendar day elimination period.

Am I eligible for disability benefits after childbirth?

Yes, if you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the eight weeks. If you have vaginal birth, you will be considered disabled for a minimum of six weeks beginning on the date of your vaginal delivery, unless you return to work prior to the end of the six weeks.

Example: You have a standard STD and have a C-section on January 29, 2011. Your waiting period is from January 29, 2011, through February 23, 2011. Your standard STD benefit begins on February 24, 2011, for four weeks.

Your rates are listed below.

	10-MONTH	11-MONTH	12-MONTH
Upgrade from Board-Paid			
Standard to Standard Upgrade	$3.28	$2.74	$2.52
High	$1.21	$1.01	$.93
High Upgrade	$5.29	$4.41	$4.07

What services does this benefit include?

STD replaces 60 percent of your earnings, up to a maximum of $500 per week. This benefit covers maternity as well as other short-term disabling illnesses or injuries. The Hartford recognizes that an employee may have additional sources of income available following a disability. To prevent over insurance, The Hartford will subtract from your gross disability payment other sources of income (see your certificate for a definition of other sources of income, if any). You do not have to use up your sick days to receive benefits. However, if you do choose to use your sick days, The Hartford will NOT subtract from the gross disability payment income you receive from salary continuation or sick leave plan.

When should I submit a claim?

Your claim should be submitted within 30 days after the date of your disability begins or as soon as possible. However, The Hartford must receive written proof of your claim no later than 90 days after your elimination period. If this is not possible, proof must be given no later than one year after the time proof is required except in the absence of legal capacity.

How do I submit a claim?

You must initiate your claim by calling The Hartford's toll-free telephonic claim intake number at 1-800-741-4306 and report your claim. **You will not** need to submit a paper claim form as the The Hartford intake specialist will take your information by phone. However, it will be your responsibility to provide an authorization form to your physician to be signed/dated and faxed or mailed to The Hartford. This allows The Hartford to access your medical records in order to process your claim.

Is there a survivor benefit?

No. There is no survivor benefit included with this Short-Term Disability plan.

What is the minimum weekly benefit?

The minimum weekly benefit is $25.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that affect any benefits payable. For complete details of coverage and availability, please contact The Hartford at 1-800-741-4306.

What are the exclusions?

The policy will not cover any disability due to:

- War or act of war (declared or not)
- Military service for any country engaged in war or other armed conflict
- The commission of, or attempt to commit a felony
- An intentional self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Any injury sustained as a result of doing any work for pay or profit for another employer
- Occupational sickness or injury covered by workers' compensation
- Elective cosmetic surgery

Are benefits taxable?

If your premiums to upgrade to the High plan are paid on a pre-tax basis, you will receive a W-2 form for the calendar year in which benefits were paid. However, if your premiums were paid on a post-tax basis, benefits paid to you will not be taxed. The premiums paid by the School Board for the Standard Disability plan will be on a pre-tax basis.

Am I eligible for benefits under this plan if I am absent from work on the plan effective date?

No. If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

What insurance company makes this plan available to me?

The Short-Term Disability benefit is offered through Hartford Life and Accident Insurance Company. The Hartford is rated "A, (Excellent)" rating effective 2010) by *A.M. Best's Reports*, which compares and rates the financial strength and performance of insurance companies.

Is Coverage guaranteed during this enrollment?

New Hires: Yes. You have the opportunity to enroll in Short-Term Disability during this enrollment period without submitting Evidence of Insurability. If you are currently eligible for coverage, but choose not to upgrade during this enrollment, future enrollments will require that you complete Evidence of Insurability and your coverage will not be guaranteed.

Current Employees: No. If you are a current employee who chose not to enroll previously in Long-Term Disability or one of the Short-Term Disability buy up plans, **you must now complete an Evidence of Insurability (EOI) form before you are considered for coverage**. Existing employees currently enrolled in one of the Short-term buy up plans or Long-term plans and not making changes during this enrollment will continue with their current coverage. New hires do not need to provide EOI. Current employees electing this benefit during the 2011 Open Enrollment must complete an EOI form which will be verified by The Hartford. If your buy up or LTD EOI is approved, the effective date of this benefit will be the first of the month following your first payroll deduction.

NOTE: Your online confirmation notice will reflect a $0.00 deduction for this benefit which will change if your EOI is approved. The deduction will be taken on the last paycheck of the month after your approval, which makes your benefit effective the first of the following month after your first payroll deduction.

EOI forms will be distributed by The Hartford. For any questions, you may call a Hartford Representative at 1-800-741-4306.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under “Important Phone Numbers.”

Long-Term Disability (LTD)

The Long-Term Disability Plan will provide you with 60 percent of your income if you are totally disabled and qualify for benefits. Total disability is the inability to perform one or more essential duties of your regular occupation and you have a 20 percent or more loss in your monthly earnings. After 24 months of payments, you are disabled when The Hartford determines that you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Am I eligible for benefits under this plan if I am absent from work on the plan effective date?

No. If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

What are the amounts of Long-Term Disability benefits available?

You can choose the level of coverage that best suits your needs. They are as follows:

Level 1: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $1,800

Level 2: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $3,000

Level 3: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $5,000

Level 4: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $7,500

Benefits are reduced by any group disability benefits received from other sources, as defined on Page 105. A person currently disabled will not be eligible to increase their benefit.

How to Select Your Level of Coverage

You should consider your annual salary when selecting a level of coverage to provide you and your family the most protection.

If your annual salary is less than $36,000, you should select Level 1 Coverage.

If your annual salary is $36,000 - $60,000, you should select Level 2 Coverage.

If your annual salary is $60,000 - $100,000, you should select Level 3 Coverage.

If your annual salary is greater than $100,000, you should select Level 4 Coverage.

What is the minimum benefit?

The minimum monthly benefit is $100, or 10 percent of your gross disability benefit, whichever is greater.

How long must I be totally disabled before I receive benefits?

There is an elimination period (benefit waiting period), during which time you must be continuously disabled and for which no benefit is payable. The elimination period begins on the first day of disability. You can satisfy your elimination period if you are working, as long as you meet the definition of disability. Your disability will be treated as continuous as long as you do not exceed 90 return-to-work days during the elimination period.

When are benefits payable?

LTD benefits begin to accrue after you meet the definition of disability as defined in the policy to satisfy a benefit waiting period of 180 days or the expiration of accrued sick leave, whichever is greater.

How long are benefits payable?

If you are disabled prior to age 62, your benefits will cover you to age 67. If you are disabled at age 62 or after, benefits will be paid according to a decreasing maximum benefit period as indicated below:

Age at Disability	Maximum Benefit Period
Less than age 62	to age 67
62	60 months
63	48 months
64	42 months
65	36 months
66	30 months
67	24 months
68	18 months
69 and over	12 months

Is coverage guaranteed during this enrollment?

New Hires: Yes. You have the opportunity to enroll in Long-Term Disability during this enrollment period without submitting Evidence of Insurability. If you are currently eligible for coverage, but choose not to enroll during this enrollment, future enrollments will require that you complete Evidence of Insurability and your coverage will not be guaranteed.

Current Employees: No. If you chose not to enroll during previous enrollments, you must now complete an Evidence of Insurability (EOI) form before you are considered for coverage. The effective date of increased amount will be the first of the month following approval and first deduction. Your current premium will continue until the upgrades are applied for the new plan year. Your Long-Term Disability will not become effective until the first of the month following approval by The Hartford.

EOI forms will be distributed by The Hartford. For any questions, you may call a representative at 305-995-4889.

Must I pay my premiums if my disability prevents me from working?

Your post-tax LTD premium payments are waived while benefits are being paid. Premiums for all levels of LTD coverage are 100 percent employee paid.

What limitations apply for Mental Illness?

The monthly benefit payments for disabilities due to sickness or injury, which are due to mental illness, will not exceed 24 months. However, any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 months.

What benefits are included in Long-Term Disability?

If you become disabled, the following benefits can help until you get back to full-time work.

Work Incentive Benefit - This benefit offers an effective incentive if you are disabled and return to work. You may receive your full disability benefit during the first 12 months after returning, as long as your benefit and earnings are not more than 100 percent of pre-disability earnings.

Rehabilitation and Return to Work Assistance - The Hartford vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help you return to productive, independent lifestyles.

Worksite Modification Benefit - The Hartford helps your employer make the worksite accommodations necessary to enable employees to return to work. This benefit reimburses your employer up to the amount equal to the amount of the maximum monthly benefit for worksite modifications for each employee.

Family Care Credit Benefit - When you are disabled and incurring child care expenses for your dependent child(ren) and participating continuously in the Rehabilitation and Return to Work Assistance program, The Hartford will, for the purpose of calculating your benefit, deduct the cost of family care from earnings received from work as part of a program of Rehabilitation, subject to limitations. The reimbursement payment will begin immediately after you start the Rehabilitation and Return to Work Program.

The child must be under 13 years of age or incapable of providing their own care on a daily basis due to their own physical handicap or mental retardation.

Worldwide Emergency Assistance Services

Worldwide Assistance

Just one phone call gives employees and their families 24-hour access to a network of emergency medical and legal resources any time they travel more than 100 miles from home.

The Hartford's Travel Assistance Program is provided by Worldwide Assistance, a Europe Assistance company and part of the world's leading assistance network.

The program provides three kinds of services for your business or vacation travel - Pre Trip Information, Emergency Medical Assistance, and Emergency Personal Services subject to terms and conditions of the policy. Of course, all our travel services are simple to take advantage of from start to finish.

Pre Trip Planning includes:

- Visa, Passport, inoculation and Immunization Requirements
- International “Hot Spots”
- Travel Advisories
- Foreign Exchange Rates
- Embassy and Consular Referrals

Emergency Medical Assistance includes:

- Medical Referrals, Medical Monitoring, and Medical Evacuation
- Repatriation
- Traveling Companion and Dependent Children Assistance
- Emergency Medical Payments
- Return of Mortal Remains
- Replacement of Medication and Eyeglasses

Emergency Personal Services includes:

- Sending and Receiving Emergency Messages
- Emergency Travel Arrangements
- Emergency Cash
- Locating Lost Items
- Legal Assistance
- Bail Advancement
- Translation

What is a recurrent disability?

A recurrent disability is a disability that is related to, or due to the same cause or causes of a prior disability for which a monthly benefit was paid. A recurrent disability will be treated as part of the prior disability and you will not have to complete another elimination period if, after receiving disability benefits under the plan, an employee returns to work on a full-time basis for less than six months and performs all of the duties of the employee's own occupation. Benefit payments will be subject to the terms of the plan for the prior disability.

What are the limitations?

The policy will not cover any disability due to:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Military service for any country engaged in war or other armed conflict

Are benefits taxable?

Because your premiums are paid on a post-tax basis, disability benefits paid to you will not be taxed.

When should I submit a claim?

Your claim should be submitted within 30 days after the date of your disability begins or as soon as possible. However, The Hartford must receive written proof of your claim no later than 90 days after your elimination period. If this is not possible, proof must be given no later than one year after the time proof is required except in the absence of legal capacity.

How do I submit a claim?

The transition process from Short Term Disability to Long Term Disability claim is automated by our claim system. A claimant questionnaire is sent to the employee that requests information about other income/offset information, past work experience/education and medical providers. We may also obtain additional information from the employer. A separate claim form is not required.

What if I receive benefits from another group disability plan or other source?

Disability benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)

Disability benefit payments will not be reduced by certain kinds of other income, such as:

- Retirement benefits if you were already receiving them before you became disabled
- Retirement benefits that are funded by your after-tax contributions
- The portion of your Long Term Disability payment that you place in an IRS-approved account to fund your future retirement.
- Your personal savings, investments, IRAs or Keoghs
- Profit-sharing
- Most personal disability policies
- Social Security increases

Is there a survivor benefit?

Yes, if you die after your disability had continued for 180 or more consecutive days; and you were receiving or were entitled to receive payments under the plan, The Hartford will pay your eligible survivor a lump sum benefit equal to three months of your gross disability payment.

Your rates are listed below. All premiums are on a post-tax basis.

	10-MONTH (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Level 1	$13.04	$10.87	$10.03
Level 2	$16.71	$13.93	$12.85
Level 3	$25.18	$20.99	$19.37

Level 4 For Level 4 coverage (available only if your salary is in excess of $100,000), determine your premium by choosing a payroll cycle and following ONE of the formulas below:

For **10-MONTH** (20 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x .95 ÷ 20 = $_____

For **11-MONTH** (24 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x .95 ÷ 24 = $_____

For **12-MONTH** (26 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x .95 ÷ 26 = $_____

* If your salary exceeds $150,000, enter $150,000 here.

Is there a pre-existing condition clause?

Yes. Your insurance limits the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your policy, you will be covered for a disability due to that condition only if:

- You have not received treatment for your condition for three months before the effective date of your insurance, or
- You have been insured under this coverage for twelve months prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
- You have already satisfied the pre-existing condition requirement of your previous insurer.

What insurance company makes this plan available?

The Long-Term Disability benefit is offered through Hartford Life and Accident Insurance Company. The Hartford is rated "A (Excellent)" (rating effective 2010) by A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

Hospital Indemnity Coverage

Hospital Indemnity Coverage provides benefits if you or your insured dependents are confined in a hospital as an inpatient. The levels of daily coverage are $50, $100 or $150. The Employee-Paid daily benefit levels combined cannot exceed $150. You must be enrolled for coverage in order to enroll your dependent(s). Coverage for your dependents cannot exceed your own.

If a child is born to anyone under this policy while family coverage is in force, the child shall automatically become a covered dependent from the moment of birth. However, you must still contact FBMC at 1-800-342-8017 and request a Change in Status form. This includes coverage for sickness or injury, and the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. Routine care for the child is not covered under this policy.

You and your dependents may select different levels of coverage as long as (a) your amount does not exceed $150 and (b) your dependent's level of coverage does not exceed your own.

Who is an eligible dependent for this coverage?

Eligible dependents covered under this plan include:

- Legal Spouse/Domestic Partner
- Unmarried children who are under age 25 provided:
  - the child is dependent upon the insured for support
  - the child is living in the insured's household, or
  - the child is a full-time or part-time student.

NOTE: 'Child' includes stepchild, legally adopted child, a child pending finalization of adoption proceedings, natural child, and children of a Domestic Partner (provided the Domestic Partner is also covered). Dependent eligibility will be determined at the time of claim.

When will my benefit payments start?

You are eligible for benefits on the first day of a covered hospitalization.

How long will the benefits continue?

These benefits are payable for each day you are confined as an inpatient in a covered hospital (see exclusions) for any period from one to 365 days. Successive periods of hospital confinement, due to the same or related causes, not separated by 60 days shall be considered as one period of hospital confinement.

Must I still pay my premiums if I am hospitalized or disabled and unable to work?

If you are confined in a hospital before your 60th birthday, coverage will be continued without further payment of premiums:

a) after you have received benefits for 60 consecutive days during which premiums are paid, and
b) while you remain in the hospital as an inpatient for the same or related injury or sickness and benefits continue to be paid to a maximum of 365 days.

If you become disabled before your 60th birthday, coverage will be continued without further payment of premiums after you have been disabled for nine (9) straight months during which premiums were paid. Premiums will continue to be waived as long as you remain hospitalized or disabled provided you are eligible to continue receiving benefits, but no more than 365 days.

Waiver of Premium applies only to you; however, coverage for your covered dependents will also be continued without further payments while premiums are waived.

When are benefits payable?

Benefits are payable for each day of a necessary hospital confinement when the insured is confined in a hospital as an inpatient as recommended by a doctor for care that is reasonably and medically necessary.

How do I obtain claim forms?

To obtain claim forms, call the FBMC Customer Care Center at 1-800-342-8017, Monday - Friday, 7 a.m. - 10 p.m. (ET).

Are benefits taxable?

The IRS may require you to pay taxes on payments you receive from the Hospital Indemnity Coverage plan under current law. For further information, consult your personal tax advisor.

Definitions

"Doctor" means a duly licensed practitioner of the healing arts acting within the scope of his/her license. Doctor does not include: the Insured or the Insured's spouse; or the Insured or the Insured spouse's child, parent, brother, sister; or a person living with the Insured.

"Hospital" means an institution which:

a) is licensed as a hospital pursuant to applicable law;
b) is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
c) is under the supervision of a staff of doctors
d) provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.)
e) has medical, diagnostic and treatment facilities, with major surgical facilities:
   1) on its premises, or
   2) available to it on a prearranged basis, and
f) charges for its services.

Is there a survivor benefit?

Yes, if benefits are unpaid at the time of your death, one lump sum payment will be made to the first surviving class of the following classes of persons:

- wife or husband
- child(ren)
- mother or father
- sister or brother

If there is no surviving member as stated above, the benefits will be paid to the Insured's estate.

What injuries or sicknesses are excluded from coverage?

Benefits will not be paid for a loss caused by or resulting from:

- Intentionally self-inflicted injuries
- Voluntary self-administration of any drug or chemical substance not prescribed by, or taken according to the directions of a doctor (accidental ingestion of a poisonous substance is not excluded)
- Driving while intoxicated or driving under the influence of a controlled substance unless administered on the advice of a doctor
- Commission or attempt to commit a felony
- Participation in a riot or insurrection
- Declared or undeclared war or act of war
- Active duty service in any armed forces (proof of service will result in a refund of premium; reserve or national guard active duty or training is not excluded unless it extends beyond 31 days)
- Elective or cosmetic surgery (unrelated to trauma, infection or other disease of the involved part, or congenital disease or anomaly of a covered dependent child, which resulted in a functional defect)
- Dental surgery, unless the surgery is the result of an accidental injury
- Confinements in hospitals owned or operated by the national government, unless a charge is made, whether or not there is insurance coverage
- Injury or sickness covered by Workers' Compensation or any occupational disease law.

Also excluded:

- Outpatient procedures
- Confinement in a clinic, facility or unit of a hospital that provides custodial care, educational care, nursing care, aged care, care for drug addicts or alcoholics or rehabilitation
- Confinement in a military or veterans hospital, contracted for, or operated by, a national government or its agency unless the services are rendered on an emergency basis and in the absence of insurance, a legal liability exists to pay the charges for services given.

What insurance company makes this plan available to me?

Life Insurance Company of North America (LINA), underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates LINA "A, Excellent."

This plan provides HOSPITAL INDEMNITY insurance only. This information is a brief description of important features of the plan. It is not a contract. Terms and conditions of coverage are set forth on Policy Form No. 604852 (FL), issued in Florida. The group policy is subject to the laws of the state in which it is issued.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

CIGNA® Hospital Indemnity Plan Coverage

Coverage at $50.00 Per Day	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$2.55	$2.13	$1.96
Employee + Family	$3.30	$2.75	$2.54
Family Only	$0.75	$0.63	$0.58

Coverage at $100.00 Per Day	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$5.10	$4.25	$3.92
Employee + Family	$6.60	$5.50	$5.08
Family Only	$1.50	$1.25	$1.15

Coverage at $150.00 Per Day	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$7.65	$6.38	$5.88
Employee + Family	$9.90	$8.25	$7.62
Family Only	$2.25	$1.88	$1.73

You may purchase $10,000 to $100,000 (in $10,000 increments) of group term life insurance. This insurance supplements your Board-provided life insurance. You can have up to $50,000 in tax-free life insurance.

Under Section 79 of the IRS Code, employees are liable to pay federal income taxes on Group Term Life insurance amounts in excess of $50,000, to the extent that the costs for amounts in excess of $50,000, less any employee contributions for the entire coverage amount, is included in the employee's gross income. This additional amount will be listed as imputed income on your W-2.

Who is eligible?

All full-time employees are eligible; however, if you are totally disabled or not in active service for other reasons, your effective date of insurance or change in coverage will be delayed until the date of your return to Active Service.

How do I obtain claim forms?

To obtain claim forms, call the MetLife onsite representative at 305-995-7029.

Are the premiums taxable?

Under current Internal Revenue Code rules and regulations, employees whose life insurance is more than $50,000 will have premiums for any amount more than $50,000 included as taxable income on their W-2 forms. Please refer all tax-related questions to your tax advisor.

How much does the plan cost?

EMPLOYEE ONLY	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
$10,000	$1.80	$1.50	$1.38
$20,000	$3.60	$3.00	$2.77
$30,000	$5.40	$4.50	$4.15
$40,000	$7.20	$6.00	$5.54
$50,000	$9.00	$7.50	$6.92
$60,000	$10.80	$9.00	$8.31
$70,000	$12.60	$10.50	$9.69
$80,000	$14.40	$12.00	$11.08
$90,000	$16.20	$13.50	$12.46
$100,000	$18.00	$15.00	$13.85

* Disability is defined as the inability to perform all the essential duties of any occupation for which you may reasonably become qualified based on training, education or experience.

Must I still pay my premiums if I'm disabled and unable to work?

If you become totally disabled prior to age 60 and that disability lasts for nine consecutive months, during which time premiums are paid, the insurance company will continue your life insurance in force without further payment of premiums if proof of such disability is provided and waiver is approved.

Is there any situation that would exclude my benefits?

If you commit suicide while you are sane or insane within two years of the effective date of coverage, benefits will not be paid; however, your beneficiary will receive a refund of the premiums you have paid for this insurance.

Also, if coverage was elected while you were on a leave of absence due to a disability and you did not return to work, benefits will not be paid. However, your beneficiary will receive a refund of the premiums you have paid for this insurance.

Does the plan pay any benefits if I am terminally ill ?

The plan will pay a lump sum—50 percent of the life insurance benefit amount in force to a maximum of $50,000 if you are terminally ill and your life expectancy is six months or less. Your benefits paid to you will reduce the death benefit. This benefit is payable only once in your lifetime.

Is there any situation that would reduce my benefit amount?

All benefits are subject to reduction after age 64 as follows:

- At age 65, to 65 percent of the original face value of coverage in force
- At age 70, to 45 percent of the original face value of coverage amount in force
- At age 75, to 30 percent of the original face value of coverage amount in force
- At age 80, to 20 percent of the original face value of coverage amount in force

Can I convert my Employee-Paid life insurance if I terminate employment?

Yes. You may apply for a conversion policy for all or any portion of life insurance in effect at termination, if you make a request. You must complete a conversion application within 31 days of termination. To request a conversion application, contact the MetLife onsite representative at 305-995-7029.

Can I continue my Employee-Paid life insurance if I retire?

Yes. Upon retirement, employees may continue their coverage at their current level of coverage subject to the maximum of their class. You may not add or increase your existing coverage. If at any time of your retirement you do NOT elect to continue this coverage, you will no longer be eligible for coverage under this plan and your group life coverage will be terminated. The maximum for actives is $100,000. The maximum for retirees is $100,000.

Additional Features:

If you participate in MetLife's Optional Life Insurance, you will receive the following additional plan features:

- **Will Preparation.** This feature is offered by Hyatt Legal Plans, a MetLife company that will provide you access to a participating plan attorney to help you prepare or update your or your spouse's will at no cost if you choose to use an attorney that participates in the network.
- **Estate Resolution Services.** This is offered by Hyatt Legal Plans, Inc., a MetLife company and provides probate services to beneficiaries who are executors or administrators of the deceased employee's estate at no additional cost. These services include telephone and office consultations to discuss matters of probate, document preparation and representation at court proceedings needed to transfer the probate assets and the completion of correspondence necessary to transfer non-probate assets.

What insurance company makes this plan available to me?

Metropolitan Life Insurance Company. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates MetLife "A+, Superior."

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to **www.dadeschools.net**.Click on Employee Benefits, then click on "Employee Benefits." Your Certificate(s) of Coverage will be located under your tab (i.e., M-DCPS Employees, Retirees, Part-Time Food Service or COBRA). If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS Web site under "Important Phone Numbers."

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life insurance coverage are set forth in Group Policy No 24400, issued in Florida. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D), provides benefits for you or your insured dependents in the event of a covered accident—on or off the job—which results in loss of life, limbs, use of limbs, eyesight, hearing or speech. You may select $25,000 to $500,000 (in $25,000 increments) of coverage.

You must be enrolled for coverage in order to cover your dependents. Your dependent's coverage is a percentage of your selected benefit amount. They are as follows:

Spouse - The spouse's benefit amount will be 40 percent of the employee's, or 50 percent if the employee has no dependent children. This amount cannot exceed $250,000.

Children - Each covered child's benefit amount will be 10 percent of the employee's, or 15 percent if the employee has no spouse. The maximum children's benefit is $25,000.

What accidents are not covered?

Benefits will not be paid for a loss caused by or resulting from:

- Sickness, physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound;
- Suicide or attempted suicide; intentionally self-inflicted injury;
- Service in the armed forces of any country or international authority, except the United States National Guard;
  Any incident related to:
  1) travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  2) travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  3) parachuting or otherwise exiting from an aircraft while such aircraft is in flight except for self preservation;
  4) travel in an aircraft or device used for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
  1) any drug, medication or sedative, unless it is: taken or used as prescribed by a Physician, or an "over the counter" drug, medication or sedative, taken as directed;
  2) alcohol in combination with any drug, medication, or sedative; or
  3) poison, gas, or fumes; or war, whether declared or undeclared; or any act of war, insurrection, rebellion, or riot; or driving a vehicle or other device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or other device was being operated.

Employees under the AFSCME bargaining units are not eligible to purchase this product.

Who is eligible?

An employee will become insured on the date the employee becomes eligible.

All full-time employees who are employed and compensated for services by the employer in accordance with the employer's general practices and work a minimum of 17 hours per week.

What injuries are covered and for how much?

Accidental Death and Dismemberment (AD&D) will pay the following percentage of the amount of coverage you purchase (from $25,000 up to $500,000 for employee coverage) if, within 365 days of an eligible accident, bodily injuries result in:

• Loss of life	100%
• Total paralysis of arms and legs	100%
• Loss of any combination of two: hands, feet or eyesight	100%
• Loss of speech and hearing in both ears	100%
• Total paralysis of both legs	50%
• Total paralysis of arm and leg on one side of the body	50%
• Loss of one hand, foot or sight in one eye	50%
• Loss of speech or hearing in both ears	50%
• Loss of thumb and index finger on the same hand	25%

For example, if you purchase $200,000 in coverage for yourself and you are in an accident that results in your death, the benefit would pay $200,000.

If the accident results in total paralysis of both your legs, the benefit would pay $100,000. If the accident results in loss of your thumb and index finger on the same hand, the benefit would pay $50,000.

If you or a dependent sustain more than one covered loss due to an accidental injury, the amount we will pay will not exceed the full amount

Benefits will be reduced based upon the age of you or your spouse:

- If you are age 65 to 69, your benefit will be reduced to 70 percent of the amount of coverage
- If you are age 70 to 74, benefits will be reduced to 45 percent of the amount of coverage.
- If you are age 75 to 79, benefits will be reduced to 30 percent of the amount of coverage.
- If you are age 80 to 84, benefits will be reduced to 15 percent of the amount of coverage.
- If you are age 85 and over, benefits will be reduced to 15 percent of the amount of coverage.
- Coverage for children ends when they no longer qualify as eligible dependents.

Can I purchase coverage for my dependents?

If you sign up for employee coverage under the Employee-Paid FlexPlan Benefit you can also choose to select coverage for your family. The amount of insurance applies to only those dependents insured at the time the loss occurs. Benefits are as follows:

- Spouse-only coverage will provide 50 percent of the employee's coverage to a maximum of $250,000
- Children-only coverage will provide 15 percent of the employee's coverage, with a maximum of $25,000 per child.
- Spouse and children coverage will provide 40 percent of the employee's coverage for the spouse and 10 percent of the employee's coverage for each dependent child, with a maximum of $25,000 per child.

How do I obtain claim forms?

To obtain claim forms, call the MetLife's onsite representative at (305) 995-7029. Note: Dependent Eligibility will be determined at the time of claim.

Can I port my Employee-Paid insurance if I terminate employment?

MetLife will reach out to you via mail to advise you of your right to port this policy.

What insurance company makes this plan available to me?

Metropolitan Life Insurance Company. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates MetLife "A+, Superior."

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life insurance coverage are set forth in Group Policy # OK 82 11 33 on Policy form # LM-2160, issued in Florida. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

Are benefits taxable?

The IRS may require you to pay taxes on payments you receive from the AD&D Coverage plan under current law. For further information, consult your personal tax advisor.

What other benefits does this policy offer?

BENEFIT	WHEN IT APPLIES	AMOUNT
SEATBELT	Upon death from injuries sustained in an accident while driving or riding as a passenger in a passenger car*, provided the person was wearing a properly fastened seat belt that meets published, US Government safety standards, is properly installed by the manufacturer and has not been altered after installation, at the time of the accident. *Passenger car is any validly registered four-wheel private passenger car. It does not include any commercially licensed car or a private car that is being sued for commercial purposes, recreation or professional racing.	An additional 10 percent of the benefit amount up to $25,000; minimum amount is $1,000. The correct position of the seat belt must be certified by the investigating officer or included in the official accident report and a copy of the police report must be submitted with a claim for this benefit.
EDUCATION*	The Child Education Benefit provides an additional benefit equal to the tuition charges for each eligible dependent child to attend college or another accredited institution for up to 4 consecutive years as long as the child is: enrolled in an accredited college, university or vocational school above the 12th grade level at the time of the employee's accidental death; or is at the 12th grade level and, within one year after the employee's accidental death, enrolls as a full-time student in an accredited college, university or vocational school.	The benefit amount will not exceed $10,000 per year and an overall maximum of 20% of the employee's AD&D Full Amount. If at the time of the accident there are no dependents who qualify for the education benefit, the plan will pay an additional benefit of $1,000 to the designated beneficiary.
SPOUSE TRAINING	If your spouse is enrolled in an accredited school on the date of your death or enrolls in such a school within 12 months of the date of your death.	The additional amount we will pay is equal to the tuition charges for 1 academic year up to $5,000 per year. The overall maximum additional benefit is 3% of the AD&D Full Amount. If there is no Spouse who qualifies, $1,000 will be paid to the beneficiary.
COBRA CONTINUATION	If benefit is paid for a covered loss of your life.	Up to $3,000 reimbursement per year for three (3) years. Minimum amount is $1,000 and maximum amount is 10% of the full amount.
HOSPITAL CONFINEMENT DAILY INCOME BENEFIT	This benefit becomes payable if a covered person is confined in a hospital as a result of an accidental injury.	Pays an additional monthly benefit equal to 1% of the AD&D Full Amount. Benefits will be determined on a pro-rate basis for partial month of confinement. If more than one confinement for any one accident, we will pay for just one hospital confinement. We will pay for the first confinement while under doctor's care.
CHILD DAY CARE BENEFIT	The Child Care Benefit provides an additional amount equal to the Child Care Center* for each eligible dependent child, 11 years of age or younger, to attend a licensed Child Care Center for up to 4 consecutive years as long as the eligible child is enrolled in a Child Care Center at the time of the employee's accidental death.	Additional amount equal to the Child Care Center* charge up to a maximum of $5,000 per year and an overall maximum of 12% of the AD&D Full Amount. *Child Care Center means a facility that is operated and licensed according to the law of the jurisdiction where it is located and provides care and supervision for children in a group setting on a regularly scheduled and daily basis. This benefit is paid quarterly when MetLife receives proof that Child Care Center charges have been paid. Payment is made to the person who pays the charges on behalf of the Child.

* If, at the time of the accident, you have coverage for your family but there is no dependent who is or could become eligible for the education or spouse education benefits, an additional benefit of $1,000 will be paid to the insured's designated beneficiary.

BENEFIT	WHEN IT APPLIES	AMOUNT
WAIVER OF PREMIUM PROVISION	The Waiver of Premium disability provision applies to total disabilities beginning before age 60. Proof that the you have been continuously, totally, disabled for at least 9 months must be provided to MetLife within 12 months of the date your total disability begins. During the waiting period, premium payment is continued through the employer and is not refundable. Waiver of Premium begins once MetLife determines proof of total disability to be satisfactory. Employees who become totally disabled on or after the effective date of coverage and: • the coverage is still in effect; • the coverage is still in effect; • the disability occurred before the employee attained age 60; and • the application for total disability is approved; Will have continuing coverage without premium payment until death. Continuation will end at the earliest of: • the date of your death • the date you are no longer • totally disabled, • the date you attain age 65, • the date you have not given us proof of total disability, and • the date you refuse to be examined by our physician At age 65, If you remain on disability, the death benefit will reduce to zero.	

Value-Added Features:

Air Bag Benefit:
If an Air Bag is deployed for the covered person during the accident and the covered person dies as a result of the accident while driving or riding in a passenger car* and wearing a properly fastened seat belt, we will pay an additional benefit of 5% of the AD&D Full Amount to a maximum of $10,000. When the Air Bag Benefit and the Seat Belt Benefit both apply, the combined additional benefit will not exceed 15% of the AD&D Full Amount, to a combined maximum of $20,000.

**Passenger Car is any validly registered four-wheel private passenger vehicle. It does not include any commercially licensed car; or a private passenger car that is being used for commercial purposes, or any vehicle used for recreational or professional racing.*

Brain Damage Benefit:
Brain Damage is a covered loss that pays a benefit equal to 100% of the AD&D Full Amount as long as the brain damage* manifests itself within 30 days of the accidental injury, the covered person requires hospitalization for at least 5 days and brain damage persists for 12 consecutive months after the injury.

**Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life.*

Child Care Benefit:
The Child Care Benefit provides an additional amount equal to the Child Care Center* charge up to a maximum of $3,000 per year and an overall maximum of 3% of the AD&D Full Amount for each eligible dependent child, 11 years of age or younger, to attend a licensed Child Care Center for up to 5 consecutive years as long as the eligible child is enrolled in a Child Care Center at the time of the employee's accidental death.
If no child qualifies, $1,000 will be paid to the covered person's beneficiary.

**Child Care Center means a facility that is operated and licensed according to the law of the jurisdiction where it is located and provides care and supervision for children in a group setting on a regularly scheduled and daily basis.*

This benefit is paid quarterly when MetLife receives proof that Child Care Center charges have been paid. Payment is made to the person who pays the charges on behalf of the Child.

Child Education Benefit:
The Child Education Benefit provides an additional benefit equal to the tuition charges for each eligible dependent child to attend college or another accredited institution for up to 4 consecutive years as long as the child is: enrolled in an accredited college, university or vocational school above the 12th grade level at the time of the employee's accidental death; or is at the 12th grade level and, within one year after the employee's accidental death, enrolls as a full-time student in an accredited college, university or vocational school. The benefit amount will not exceed the lesser of 3% or $7,500 per year and an overall maximum of 20% of the employee's AD&D Full Amount.

If at the time of the accident there are no dependents who qualify for the education benefit, the plan will pay an additional benefit of $1,000 to the designated beneficiary.

Coma Benefit:
Coma is a covered loss that provides a benefit amount of 1% monthly of the AD&D Full Amount up to a maximum of 60 months if a covered person goes into a coma* as a result of an accidental injury and independent of other causes. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

**Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused.*

Common Carrier Benefit:
The Common Carrier Benefit pays an additional benefit in an amount equal to 100% of the AD&D Full Amount if a covered person dies as a result of an accidental injury while traveling in a Common Carrier*.

**Common Carrier means a government regulated entity that is in the business of transporting fare-paying passenger. This does not include chartered or other privately arranged transportation, taxis, or limousines.*

Common Disaster Benefit for VADD:
If the employee and the employee's spouse are injured in the same accident and die as a result of injuries sustained in the accident, the spouse's benefit amount will be increased to 100% of the VAD&D Full Amount payable for the employee's loss of life.* In Texas, Children age 25 only and Student age 25 only.

Exposure:
MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Full Amount:
Regarding Accidental Death & Dismemberment, the scheduled dollar benefit amount for an accidental death and certain accidental injuries.

Hospitalized:
Includes inpatient hospital care, care in a hospice, intermediate or long-term care facility, or receipt of chemotherapy, radiation therapy, or dialysis treatment wherever performed.

Hospital Confinement Benefit:
Hospital Confinement Benefit pays an additional monthly benefit equal to 1/30th of 1% of the AD&D Full Amount if a covered person is confined in a Hospital as a result of an accidental injury. Benefits begin on the 5th day of continuous confinement and are subject to a monthly limit of $2,500 and a maximum duration of 12 continuous months.

Benefits will be determined on a pro-rate basis for partial month of confinement. If more than one confinement for any one accident, we will pay for just one hospital confinement. We will pay for the first confinement.

**Hospital means a facility which is licensed as such in the jurisdiction in which it is located and; provides a broad range of medical and surgical services on a 24 hour a day basis for injured and sick persons by or under the supervision of staff of Physicians; and provides a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.*

Travel Assistance & Identity Theft Solutions:
Employees and their dependents enrolled in MetLife's Accidental Death & Dismemberment coverage will have access to Travel Assistance services that provide immediate access to doctors, hospitals, pharmacies, and certain other services when faced with an emergency while traveling internationally or domestically more than 100 miles from home.

Covered employees and their dependents may travel (together or separately) with greater peace of mind knowing that they are just one phone call away from being connected to a global alarm center to provide vital assistance services including: Medical Consultation and Evaluation, Emergency Evacuation, Dispatch of Prescription Medication, and even Emergency Message Transmission.

Identity Theft Solutions, an additional benefit packaged with Travel Assistance, educates participants on preventing identify theft and provides personal assistance and guidance to help alleviate the stress and time burden that victims of identity theft often face. This important feature can be used while the Participant is home or away and is available 24 hours a day 365 days a year. Participants receive assistance with filing police reports, contacting creditor fraud departments, taking inventory of lost or stolen items and more.

There is no travel requirement and no additional charge for Identity Theft Solutions.

Travel Assistance services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by ACE American Insurance Company. AXA Assistance and ACE American are not affiliated with MetLife, and the Travel Assistance & Identity Theft Solutions services they provide are separate and apart from the insurance provided by MetLife.

Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

Presumption of Death:
A person will be presumed to have died as a result of an accidental injury if the aircraft or other vehicle in which the person is traveling disappears, sinks or is wrecked and the person's body is not found within 1 year of the date the aircraft or vehicle was scheduled to have arrived at its destination, or, if not a Common Carrier, the date the person was reported missing to authorities.

Seat Belt Benefit:
Seat Belt Benefit provides an additional benefit equal to 10% of the AD&D Full Amount , subject to a minimum benefit of $1,000, up to a maximum of $10,000 if a covered person dies from injuries sustained in an accident while driving or riding as a passenger in a Passenger Car*, provided the person was wearing a properly fastened Seat Belt* at the time of the accident. When the Seat Belt Benefit and the Air Bag Benefit both apply, the combined additional benefit will not exceed 15% of the AD&D Full Amount, to a combined maximum of $20,000.

**Passenger Car: Any validly registered four-wheel private passenger car. It does not include any commercially licensed car; or a private car that is being used for commercial purposes, or any vehicle used for recreation or professional racing.*

**Seat Belt means any restraint device that meets published, US Government safety standards, is properly installed by the car manufacturer and has not been altered after installation. The term also includes a child restraint device that meets the requirements of state law.*

The correct position of the seat belt must be certified by the investigating officer or included in the official accident report, and a copy of the police report must be submitted with a claim for this benefit..

Spouse Education Benefit:
If the Spouse is enrolled in an accredited school on the date the covered employee dies, or enrolls in such a school within 12 months of the employee's death, the additional amount we will pay is equal to the tuition charges for 1 academic year up to $3,000 per year.

If there is no Spouse who qualifies, $1,000 will be paid to the beneficiary.

What insurance company makes this plan available to me?

Metropolitan Life Insurance Company, underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates MetLife "A+ Superior"

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Your Personal Insurance rates are listed below.

Accidental Death and Dismemberment (AD&D)

Employee Coverage

	10-MONTH (20 Deductions)			11-MONTH (24 Deductions)			12-MONTH (26 Deductions)		
	EE Only	EE & Family	Family Only	EE Only	EE & Family	Family Only	EE Only	EE & Family	Family Only
$25,000	$0.20	$0.39	$0.20	$0.16	$0.33	$0.16	$0.15	$0.30	$0.15
$50,000	$0.39	$0.78	$0.39	$0.33	$0.65	$0.33	$0.30	$0.60	$0.30
$75,000	$0.59	$1.17	$0.59	$0.49	$0.98	$0.49	$0.45	$0.90	$0.45
$100,000	$0.78	$1.56	$0.78	$0.65	$1.30	$0.65	$0.60	$1.20	$0.60
$125,000	$0.98	$1.95	$0.98	$0.81	$1.63	$0.81	$0.75	$1.50	$0.75
$150,000	$1.17	$2.34	$1.17	$0.98	$1.95	$0.98	$0.90	$1.80	$0.90
$175,000	$1.37	$2.73	$1.37	$1.14	$2.28	$1.14	$1.05	$2.10	$1.05
$200,000	$1.56	$3.12	$1.56	$1.30	$2.60	$1.30	$1.20	$2.40	$1.20
$225,000	$1.76	$3.51	$1.76	$1.46	$2.93	$1.46	$1.35	$2.70	$1.35
$250,000	$1.95	$3.90	$1.95	$1.63	$3.25	$1.63	$1.50	$3.00	$1.50
$275,000	$2.15	$4.29	$2.15	$1.79	$3.58	$1.79	$1.65	$3.30	$1.65
$300,000	$2.34	$4.68	$2.34	$1.95	$3.90	$1.95	$1.80	$3.60	$1.80
$325,000	$2.54	$5.07	$2.54	$2.11	$4.23	$2.11	$1.95	$3.90	$1.95
$350,000	$2.73	$5.46	$2.73	$2.28	$4.55	$2.28	$2.10	$4.20	$2.10
$375,000	$2.93	$5.85	$2.93	$2.44	$4.88	$2.44	$2.25	$4.50	$2.25
$400,000	$3.12	$6.24	$3.12	$2.60	$5.20	$2.60	$2.40	$4.80	$2.40
$425,000	$3.32	$6.63	$3.32	$2.76	$5.53	$2.76	$2.55	$5.10	$2.55
$450,000	$3.51	$7.02	$3.51	$2.93	$5.85	$2.93	$2.70	$5.40	$2.70
$475,000	$3.71	$7.41	$3.71	$3.09	$6.18	$3.09	$2.85	$5.70	$2.85
$500,000	$3.90	$7.80	$3.90	$3.25	$6.50	$3.25	$3.00	$6.00	$3.00

Benefit payout will be:

Spouse only coverage =	50 percent of employee's coverage
Children only coverage =	15 percent of employee coverage
Spouse & Children =	Spouse 40 percent of employee's coverage Each child 10 percent of employee's coverage

FBMC Privacy Notice 4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:
   - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
   - Responses from you and others such as information relating to your employment and insurance coverage.
   - Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
   - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

   Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: **www.myFBMC.com**. You have a right to a paper copy at any time. Contact the FBMC Customer Care Center at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder, and the insurer:

1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

Taxable Benefits and the IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pre-tax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual medical expenses you incur, if these premiums were paid with pre-tax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than:

- 48 hours following a vaginal delivery; OR
- 96 hours following a cesarean section

Determination of when the hospital stay begins is based on the following:

- For an in the hospital delivery:
- The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center):
- The stay begins at the time of admission to the hospital.
- Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.
- These rules do not mandate hospital stay benefits on a plan that does not provide that coverage.
- The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

Importance Notice

CREDITABLE COVERAGE DISCLOSURE NOTICE
FOR ACTIVE EMPLOYEES AND/OR THEIR DEPENDENTS

Please read this notice carefully and keep it for your records.

Under the Medicare Modernization Act of 2003, a new Medicare-Approved Drug Plan (Part D) took effect as of January 1, 2006. This is your notice of creditable coverage.

- Your prescription drug coverage offered by CIGNA Healthcare Plans, is, on average, as good or better as the standard Medicare prescription drug coverage.
- If you select one of the CIGNA Healthcare Plans, you will not be penalized by Medicare if you decline to enroll in Medicare Part D at this time and decide to enroll in it at a later date. You will not have to pay the increased premium of at least one percent for each month that you did not elect to enroll in this plan after December 31, 2010 for an effective date of January 1, 2011.
- Creditable coverage means that the prescription drug coverage offered to you by the healthcare plan is, on average, as good as Medicare Part D coverage.

Medicare recipients can enroll in the Medicare Part D Prescription Drug Plan from November 15, 2010, through December 31, 2010.

For more information refer to your "Medicare & You 2011" handbook provided to you by Medicare, or by logging into **www.medicare.gov** or calling 1-800-MEDICARE (1-500-633-4227). TTY users should call 1-877-486-2048.

WHEN TO ENROLL IN MEDICARE PARTS A & B:

Active Employees Eligible for Medicare Parts A & B:

If you and/or your covered dependent are eligible for Medicare Parts A & B, you are provided the opportunity of enrolling in Medicare during the Special Enrollment Period. However, you do not need to enroll in Medicare while working and covered by a group healthcare plan through your employer. Please refer to your 2011 Medicare & You Book or by logging onto **www.medicare.gov**.

Medical Premiums - *Employee Cost Share*

Full Time - Salary <= $25k		10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
CIGNA - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse	$73.20	$61.00	$56.31
	Family	$138.00	$115.00	$106.15
	Children	$54.00	$45.00	$41.54
CIGNA - OAP10	Employee	*$45.60	*$38.00	*$35.08
	Spouse	$64.80	$54.00	$49.85
	Family	$129.00	$107.50	$99.23
	Children	$45.60	$38.00	$35.08

* Employee Only Rate must be added to the dependent rate, i.e., spouse/domestic partner, child(ren), or family to get the total deduction per paycheck.

Full Time - Salary >25k - 40k		10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
CIGNA - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse	$109.20	$91.00	$84.00
	Family	$195.60	$163.00	$150.46
	Children	$84.00	$70.00	$64.62
CIGNA - OAP10	Employee	*$60.60	*$50.50	*$46.62
	Spouse	$86.40	$72.00	$66.46
	Family	$172.20	$143.50	$132.46
	Children	$60.60	$50.50	$46.62

* Employee Only Rate must be added to the dependent rate, i.e., spouse/domestic partner, child(ren), or family to get the total deduction per paycheck.

Full Time - Salary > 40k - 55k		10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
CIGNA - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse	$171.60	$143.00	$132.00
	Family	$276.00	$230.00	$212.31
	Children	$136.80	$114.00	$105.23
CIGNA - OAP10	Employee	*$69.60	*$58.00	*$53.54
	Spouse	$139.20	$116.00	$107.08
	Family	$244.20	$203.50	$187.85
	Children	$104.40	$87.00	$80.31

* Employee Only Rate must be added to the dependent rate, i.e., spouse/domestic partner, child(ren), or family to get the total deduction per paycheck.

Full Time - Salary >55k - 85k		10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
CIGNA - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse	$198.60	$165.50	$152.77
	Family	$316.80	$264.00	$243.69
	Children	$159.00	$132.50	$122.31
CIGNA - OAP10	Employee	*$78.60	*$65.50	*$60.46
	Spouse	$157.20	$131.00	$120.92
	Family	$275.40	$229.50	$211.85
	Children	$118.20	$98.50	$90.92

* Employee Only Rate must be added to the dependent rate, i.e., spouse/domestic partner, child(ren), or family to get the total deduction per paycheck.

Full Time - Salary >85k		10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
CIGNA - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse	$225.60	$188.00	$173.54
	Family	$357.00	$297.50	$274.62
	Children	$181.80	$151.50	$139.85
CIGNA - OAP10	Employee	*$87.60	*$73.00	*$67.38
	Spouse	$175.20	$146.00	$134.77
	Family	$307.20	$256.00	$236.31
	Children	$131.40	$109.50	$101.08

* Employee Only Rate must be added to the dependent rate, i.e., spouse/domestic partner, child(ren), or family to get the total deduction per paycheck.

Disability Insurance

The Hartford Employee Coverage

Short-Term	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Standard Upgrade	$3.28	$2.74	$2.52
High	$1.21	$1.01	$0.93
High Upgrade	$5.29	$4.41	$4.07

Long-Term	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Level 1	$13.04	$10.87	$10.03
Level 2	$16.71	$13.93	$12.85
Level 3	$25.18	$20.99	$19.37

Level 4 For Level 4 coverage (available only if your salary is in excess of $100,000), determine your premium by choosing a payroll cycle and following ONE of the formulas below:

For **10-MONTH** (20 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06 ÷ 20 = $_____

For **11-MONTH** (24 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06 ÷ 24 = $_____

For **12-MONTH** (20 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06 ÷ 26 = $_____

* If your salary exceeds $150,000, enter $150,000 here.

Dental

SafeGuard DHMO Plans

	10-MONTH (20 Deductions)		**11-MONTH** (24 Deductions)		**12-MONTH** (26 Deductions)	
	High	Standard	High	Standard	High	Standard
Employee	$6.34	$4.48	$5.28	$3.73	$4.87	$3.44
Employee & Family	$16.17	$11.41	$13.48	$9.51	$12.44	$8.78

MetLife Dental Plan

Standard Indemnity	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$9.97	$8.31	$7.67
Employee & Family	$30.59	$25.49	$23.53

High Indemnity	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$20.83	$17.36	$16.02
Employee & Family	$62.27	$51.90	$47.90

Vision

UnitedHealthcare Vision Plan

	10-MONTH (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$3.46	$2.88	$2.66
Employee & Family	$8.64	$7.20	$6.65

Identity Theft

ID Watchdog Identity Theft Plan

	10-MONTH (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$4.77	$3.98	$3.67
Employee & Family	$8.97	$7.48	$6.90

Hospital Indemnity Plan Coverage

CIGNA® Hospital Indemnity Plan Coverage

Coverage at $50.00 Per Day	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$2.55	$2.13	$1.96
Employee + Family	$3.30	$2.75	$2.54
Family Only	$0.75	$0.63	$0.58

Coverage at $100.00 Per Day	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$5.10	$4.25	$3.92
Employee + Family	$6.60	$5.50	$5.08
Family Only	$1.50	$1.25	$1.15

Coverage at $150.00 Per Day	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
Employee	$7.65	$6.38	$5.88
Employee + Family	$9.90	$8.25	$7.62
Family Only	$2.25	$1.88	$1.73

MetLife Life Insurance

Employee Only	**10-MONTH** (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
$10,000	$1.80	$1.50	$1.38
$20,000	$3.60	$3.00	$2.77
$30,000	$5.40	$4.50	$4.15
$40,000	$7.20	$6.00	$5.54
$50,000	$9.00	$7.50	$6.92
$60,000	$10.80	$9.00	$8.31
$70,000	$12.60	$10.50	$9.69
$80,000	$14.40	$12.00	$11.08
$90,000	$16.20	$13.50	$12.46
$100,000	$18.00	$15.00	$13.85

Legal Coverage

ARAG

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
ARAG Group Legal Plan	$10.38	$8.65	$7.98
ARAG Senior Advocate Program	$4.66	$3.88	$3.58

US Legal Plans

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH (20 Deductions)	**11-MONTH** (24 Deductions)	**12-MONTH** (26 Deductions)
US Legal Family Protector	$10.14	$8.45	$7.80
US Legal Senior Protector	$4.65	$3.88	$3.58

Accidental Death & Dismemberment

Accidental Death and Dismemberment (AD&D)

Employee Coverage

	10-MONTH (20 Deductions)			11-MONTH (24 Deductions)			12-MONTH (26 Deductions)		
	EE Only	EE & Family	Family Only	EE Only	EE & Family	Family Only	EE Only	EE & Family	Family Only
$25,000	$0.20	$0.39	$0.20	$0.16	$0.33	$0.16	$0.15	$0.30	$0.15
$50,000	$0.39	$0.78	$0.39	$0.33	$0.65	$0.33	$0.30	$0.60	$0.30
$75,000	$0.59	$1.17	$0.59	$0.49	$0.98	$0.49	$0.45	$0.90	$0.45
$100,000	$0.78	$1.56	$0.78	$0.65	$1.30	$0.65	$0.60	$1.20	$0.60
$125,000	$0.98	$1.95	$0.98	$0.81	$1.63	$0.81	$0.75	$1.50	$0.75
$150,000	$1.17	$2.34	$1.17	$0.98	$1.95	$0.98	$0.90	$1.80	$0.90
$175,000	$1.37	$2.73	$1.37	$1.14	$2.28	$1.14	$1.05	$2.10	$1.05
$200,000	$1.56	$3.12	$1.56	$1.30	$2.60	$1.30	$1.20	$2.40	$1.20
$225,000	$1.76	$3.51	$1.76	$1.46	$2.93	$1.46	$1.35	$2.70	$1.35
$250,000	$1.95	$3.90	$1.95	$1.63	$3.25	$1.63	$1.50	$3.00	$1.50
$275,000	$2.15	$4.29	$2.15	$1.79	$3.58	$1.79	$1.65	$3.30	$1.65
$300,000	$2.34	$4.68	$2.34	$1.95	$3.90	$1.95	$1.80	$3.60	$1.80
$325,000	$2.54	$5.07	$2.54	$2.11	$4.23	$2.11	$1.95	$3.90	$1.95
$350,000	$2.73	$5.46	$2.73	$2.28	$4.55	$2.28	$2.10	$4.20	$2.10
$375,000	$2.93	$5.85	$2.93	$2.44	$4.88	$2.44	$2.25	$4.50	$2.25
$400,000	$3.12	$6.24	$3.12	$2.60	$5.20	$2.60	$2.40	$4.80	$2.40
$425,000	$3.32	$6.63	$3.32	$2.76	$5.53	$2.76	$2.55	$5.10	$2.55
$450,000	$3.51	$7.02	$3.51	$2.93	$5.85	$2.93	$2.70	$5.40	$2.70
$475,000	$3.71	$7.41	$3.71	$3.09	$6.18	$3.09	$2.85	$5.70	$2.85
$500,000	$3.90	$7.80	$3.90	$3.25	$6.50	$3.25	$3.00	$6.00	$3.00

Benefit payout will be:

Spouse only coverage =	50 percent of employee's coverage
Children only coverage =	15 percent of employee coverage
Spouse & Children =	Spouse 40 percent of employee's coverage
	Each child 10 percent of employee's coverage

FBMC
Premier Benefits Solutions

Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Care 1-800-342-8017 • 1-800-955-8771 (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

FBMC/M-DCPS/1110

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