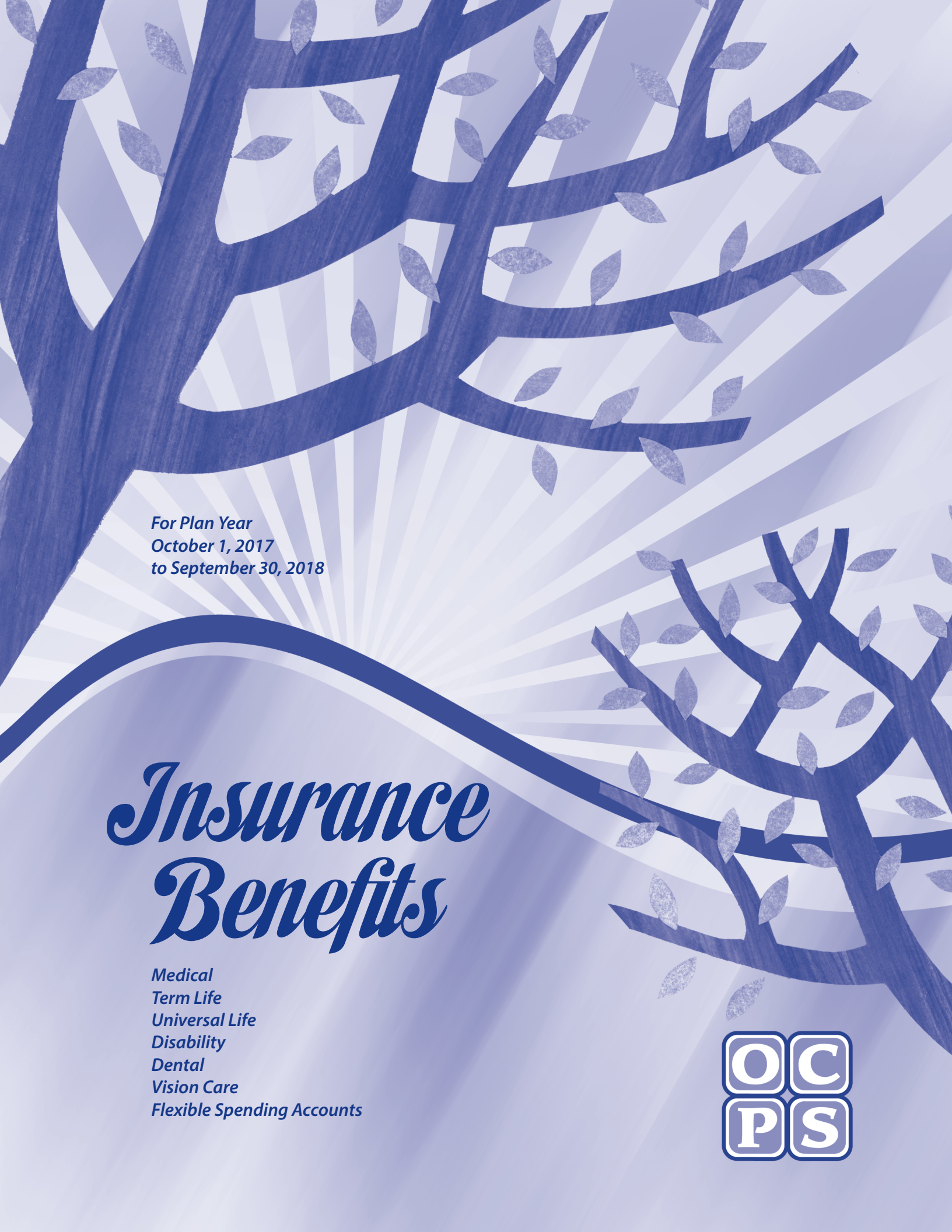

*For Plan Year*
*October 1, 2017*
*to September 30, 2018*

# Insurance Benefits

*Medical*
*Term Life*
*Universal Life*
*Disability*
*Dental*
*Vision Care*
*Flexible Spending Accounts*

OCPS

# 2017 - 2018 INSURANCE BENEFITS RATE SHEET

**Monthly/Biweekly Payroll Deductions**

Deductions are taken Biweekly over 10 months (September-June) each plan year for 12 months of coverage.

## MEDICAL INSURANCE

| | A. Cigna Local Plus OAP In-Network | | B. Cigna Health Reimbursement Account | | C. Cigna OAP In-Network (formerly Network PREMIUM) | |
|---|---|---|---|---|---|---|
| | Monthly | Biweekly | Monthly | Biweekly | Monthly | Biweekly |
| Employee Only | OCPS-Paid | | $37.28 | $18.64 | $37.28 | $18.64 |
| Employee + Children | $50.00 | $25.00 | $603.54 | $301.77 | $370.30 | $185.15 |
| Employee + Spouse/Same-sex Domestic Partner (DP) | $250.00 | $125.00 | $840.12 | $420.06 | $586.40 | $293.20 |
| Employee + Children + Spouse/DP | $300.00 | $150.00 | $1,060.86 | $530.43 | $788.00 | $394.00 |
| Half-Family (Spouse or same-sex domestic partners are OCPS employees covering their dependents and paying this deduction.) | OCPS-Paid | | $108.22 | $54.11 | $37.28 | $18.64 |
| Part-Time Employee Only* | $422.20 | $211.10 | $459.48 | $229.74 | $459.48 | $229.74 |

***Part-time employees, add $211.10 to the biweekly dependent rate listed above to obtain your biweekly payroll deduction.**

**The Orange County School Board pays $844.42 per month for each full-time benefited employee. For the 2017-18 plan year, that equates to $8,444.20.**

## D. ALTERNATIVE TO MEDICAL Insurance Option

Disability/Vision Plan - OCPS Paid

## TERM LIFE INSURANCE

**A. OCPS-Paid Life Insurance - NO MONTHLY PREMIUM**

**B. Dependent Life Insurance - IF YOUR BASE SALARY IS:**

| Class | Monthly | Biweekly | Salary |
|---|---|---|---|
| Class I | $3.38 | $1.69 | $20,000 or more |
| Class II | $2.52 | $1.26 | less than $20,000 |
| Class III | $1.70 | $0.85 | less than $15,000 |
| Class IV | $1.26 | $0.63 | less than $10,000 |

**C. Group Universal Life Insurance - Employee or Spouse/Domestic Partner**

| Age | Monthly Payroll Deduction for Each $10,000 | Biweekly Payroll Deduction for Each $10,000 |
|---|---|---|
| Under 25 | $0.44 | $0.22 |
| 25-29 | $0.54 | $0.27 |
| 30-34 | $0.70 | $0.35 |
| 35-39 | $0.78 | $0.39 |
| 40-44 | $0.88 | $0.44 |
| 45-49 | $1.34 | $0.67 |
| 50-54 | $1.98 | $0.99 |
| 55-59 | $3.70 | $1.85 |
| 60-64 | $5.68 | $2.84 |
| 65-69 | $10.92 | $5.46 |
| 70-74 | $17.70 | $8.85 |

Child Term Insurance Rider Available: Biweekly rate for $5,000 = $.92 for all eligible dependent children; Biweekly rate for $10,000 = $1.84 for all eligible dependent children. Premiums payable may be subject to minor adjustments (upwards and downwards) due to rounding of rates. Please contact Minnesota Life at 1.800.843.8358 to determine actual premiums due.

## DENTAL INSURANCE

| | *A. DeltaCare®USA Managed Dental* | | | | *B. DeltaDental PPO* | |
|---|---|---|---|---|---|---|
| | Basic | | Comprehensive | | | |
| | Monthly | Biweekly | Monthly | Biweekly | Monthly | Biweekly |
| Employee Only | $9.62 | $4.81 | $15.74 | $7.87 | $41.16 | $20.58 |
| Employee + 1 Dependent | $15.90 | $7.95 | $29.44 | $14.72 | $70.68 | $35.34 |
| Employee + 2 or more Dependents | $23.50 | $11.75 | $36.04 | $18.02 | $101.08 | $50.54 |

## VISION INSURANCE

| Vision Care Plan | Monthly | Biweekly |
|---|---|---|
| Employee Only | $6.32 | $3.16 |
| Employee + Dependents | $17.50 | $8.75 |

# DISABILITY INSURANCE

| Minimum Annual Salary | Accident and Illness Monthly* Disability Benefits | *The monthly disability benefit level reflected in this chart is an average benefit. The actual amount paid varies since the monthly benefit is calculated on an annual basis to determine the weekly benefit that is payable by Lincoln. The benefit is based on 52 weeks in a year and is dependent on the number of days in the associated month. When Accident and Illness Benefits Begin after: | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 14 Days | | 30 Days | | 60 Days | | 180 Days | |
| | | Monthly Rate | Biweekly Rate | Monthly Rate | Biweekly Rate | Monthly Rate | Biweekly Rate | Monthly Rate | Biweekly Rate |
| $3,600 | $200 | $6.38 | $3.19 | $4.78 | $2.39 | $3.58 | $1.79 | $2.42 | $1.21 |
| $5,400 | $300 | $9.56 | $4.78 | $7.16 | $3.58 | $5.38 | $2.69 | $3.62 | $1.81 |
| $7,200 | $400 | $12.74 | $6.37 | $9.54 | $4.77 | $7.18 | $3.59 | $4.84 | $2.42 |
| $9,000 | $500 | $15.94 | $7.97 | $11.94 | $5.97 | $8.97 | $4.49 | $6.04 | $3.02 |
| $10,800 | $600 | $19.12 | $9.56 | $14.32 | $7.16 | $10.76 | $5.38 | $7.26 | $3.63 |
| $12,600 | $700 | $22.30 | $11.15 | $16.70 | $8.35 | $12.54 | $6.27 | $8.46 | $4.23 |
| $14,400 | $800 | $25.48 | $12.74 | $19.10 | $9.55 | $14.34 | $7.17 | $9.68 | $4.84 |
| $16,200 | $900 | $28.68 | $14.34 | $21.48 | $10.74 | $16.14 | $8.07 | $10.88 | $5.44 |
| $18,000 | $1,000 | $31.86 | $15.93 | $23.86 | $11.93 | $17.92 | $8.96 | $12.10 | $6.05 |
| $19,800 | $1,100 | $35.04 | $17.52 | $26.26 | $13.13 | $19.72 | $9.86 | $13.30 | $6.65 |
| $21,600 | $1,200 | $38.24 | $19.12 | $28.64 | $14.32 | $21.52 | $10.76 | $14.52 | $7.26 |
| $23,400 | $1,300 | $41.42 | $20.71 | $31.02 | $15.51 | $23.30 | $11.65 | $15.72 | $7.86 |
| $25,200 | $1,400 | $44.60 | $22.30 | $33.42 | $16.71 | $25.10 | $12.55 | $16.94 | $8.47 |
| $27,000 | $1,500 | $47.80 | $23.90 | $35.81 | $17.91 | $26.90 | $13.45 | $18.14 | $9.07 |
| $28,800 | $1,600 | $50.98 | $25.49 | $38.18 | $19.09 | $28.68 | $14.34 | $19.36 | $9.68 |
| $30,600 | $1,700 | $54.16 | $27.08 | $40.58 | $20.29 | $30.48 | $15.24 | $20.56 | $10.28 |
| $32,400 | $1,800 | $57.34 | $28.67 | $42.96 | $21.48 | $32.28 | $16.14 | $21.78 | $10.89 |
| $34,200 | $1,900 | $60.54 | $30.27 | $45.34 | $22.67 | $34.06 | $17.03 | $22.98 | $11.49 |
| $36,000 | $2,000 | $63.72 | $31.86 | $47.74 | $23.87 | $35.86 | $17.93 | $24.20 | $12.10 |
| $37,800 | $2,100 | $66.90 | $33.45 | $50.12 | $25.06 | $37.64 | $18.82 | $25.40 | $12.70 |
| $39,600 | $2,200 | $70.10 | $35.05 | $52.50 | $26.25 | $39.44 | $19.72 | $26.62 | $13.31 |
| $41,400 | $2,300 | $73.28 | $36.64 | $54.90 | $27.45 | $41.24 | $20.62 | $27.82 | $13.91 |
| $43,200 | $2,400 | $76.47 | $38.24 | $57.28 | $28.64 | $43.02 | $21.51 | $29.04 | $14.52 |
| $45,000 | $2,500 | $79.66 | $39.83 | $59.68 | $29.84 | $44.82 | $22.41 | $30.24 | $15.12 |
| $46,800 | $2,600 | $82.84 | $41.42 | $62.06 | $31.03 | $46.62 | $23.31 | $31.44 | $15.72 |
| $48,600 | $2,700 | $86.02 | $43.01 | $64.44 | $32.22 | $48.40 | $24.20 | $32.65 | $16.33 |
| $50,400 | $2,800 | $89.20 | $44.60 | $66.84 | $33.42 | $50.20 | $25.10 | $33.86 | $16.93 |
| $52,200 | $2,900 | $92.40 | $46.20 | $69.22 | $34.61 | $52.00 | $26.00 | $35.08 | $17.54 |
| $54,000 | $3,000 | $95.58 | $47.79 | $71.61 | $35.81 | $53.78 | $26.89 | $36.28 | $18.14 |
| $55,800 | $3,100 | $98.76 | $49.38 | $74.00 | $37.00 | $55.58 | $27.79 | $37.50 | $18.75 |
| $57,600 | $3,200 | $101.96 | $50.98 | $76.38 | $38.19 | $57.36 | $28.68 | $38.70 | $19.35 |
| $59,400 | $3,300 | $105.14 | $52.57 | $78.77 | $39.39 | $59.16 | $29.58 | $39.92 | $19.96 |
| $61,200 | $3,400 | $108.32 | $54.16 | $81.16 | $40.58 | $60.96 | $30.48 | $41.12 | $20.56 |
| $63,000 | $3,500 | $111.51 | $55.76 | $83.54 | $41.77 | $62.74 | $31.37 | $42.34 | $21.17 |
| $64,800 | $3,600 | $114.70 | $57.35 | $85.92 | $42.96 | $64.55 | $32.28 | $43.54 | $21.77 |
| $66,600 | $3,700 | $117.88 | $58.94 | $88.32 | $44.16 | $66.34 | $33.17 | $44.76 | $22.38 |
| $68,400 | $3,800 | $121.06 | $60.53 | $90.70 | $45.35 | $68.12 | $34.06 | $45.96 | $22.98 |
| $70,200 | $3,900 | $124.26 | $62.13 | $93.08 | $46.54 | $69.92 | $34.96 | $47.18 | $23.59 |
| $72,000 | $4,000 | $127.44 | $63.72 | $95.48 | $47.74 | $71.72 | $35.86 | $48.38 | $24.19 |
| $81,000 | $4,500 | $143.38 | $71.69 | $107.40 | $53.70 | $80.67 | $40.34 | $54.44 | $27.22 |
| $90,000 | $5,000 | $159.31 | $79.66 | $119.34 | $59.67 | $89.64 | $44.82 | $60.48 | $30.24 |
| $99,000 | $5,500 | $175.24 | $87.62 | $131.28 | $65.64 | $98.60 | $49.30 | $66.52 | $33.26 |
| $108,000 | $6,000 | $191.16 | $95.58 | $143.20 | $71.60 | $107.56 | $53.78 | $72.58 | $36.29 |
| $117,000 | $6,500 | $207.10 | $103.55 | $155.15 | $77.58 | $116.54 | $58.27 | $78.62 | $39.31 |
| $126,000 | $7,000 | $223.02 | $111.51 | $167.08 | $83.54 | $125.50 | $62.75 | $84.68 | $42.34 |
| $135,000 | $7,500 | $238.96 | $119.48 | $179.02 | $89.51 | $134.46 | $67.23 | $90.72 | $45.36 |

# I. GENERAL INSURANCE INFORMATION

**A. ENROLLMENT INFORMATION**

**B. PLAN OVERVIEWS**

**C. FREQUENTLY CALLED PHONE NUMBERS**

**D. WEBSITES FOR PROVIDER DIRECTORIES**

**E. QUESTIONS AND ANSWERS ABOUT SECTION 125**

**F. CONTINUATION OF HEALTH COVERAGE INFORMATION**

**G. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**H. HEALTH INSURANCE REQUIRED NOTICES AND DISCLOSURES**

**I. PLAN ADMINISTRATION**

# A. ENROLLMENT INFORMATION

## *ELIGIBILITY*

Benefits are generally limited to:

### *Employees*

1. All full-time employees working 25 hours or more per week and regular part-time active employees working a minimum of 17.5 hours per week will be eligible for benefits following a waiting period of 59 days, with coverage to be effective on the first day of the following month.
   *Full-time employees may not be covered as a dependent on another OCPS medical plan.*

**In order to have any coverage, all eligible new employees must complete the enrollment process through Employee Self-Service. Full-time employees who do not make a medical plan or alternative to medical plan selection will be automatically enrolled with employee-only coverage in the Cigna Local Plus In-network plan (Plan A). Once enrolled, Employees cannot change the plan until the next Annual Enrollment.**

### *Dependents*

The following definition of dependents applies to the medical plan. Dependent children and domestic partner eligibility will vary by type of coverage (i.e. dental, vision, life). Review specific plan details for more information. Employees must provide documented proof of dependency at the time of enrollment or as requested by the Insurance Benefits department. Failure to provide documented proof of dependency will result in termination of the dependent on the last day of the month, following 60 days from the date of notification to the Employee, by regular U.S. Mail to the Employee's last known address as shown by the records of OCPS.

1. Spouse (supported by a marriage certificate)

2. The Employee's same-sex domestic partner (as supported by the OCPS Domestic Partner Affidavit, proof of residency and financial co-dependence). A domestic partner must meet the following requirements to enroll in a medical plan:

   a. Same gender as employee.
   b. Must be 18 years of age and mentally competent.
   c. Not related by blood in a manner that would bar marriage under Florida law.
   d. The domestic partner must be the Employee's "sole spousal equivalent" and not married to or partnered with any other spouse, spousal equivalent or domestic partner.
   e. The employee and domestic partner must share the same residence and live together in an exclusive, committed relationship and intend to do so indefinitely.
   f. Must assume joint responsibility for basic living expenses—food, shelter, common necessities of life and welfare.
   g. Neither partner has had another domestic partner at any time during the twelve (12) months preceding enrollment. (The length of cohabitation is waived for first time domestic partner applicants.)

3. A child of the covered Employee or the covered Employee's spouse through the end of the calendar year in which the child attains the age of 26 (as supported by a birth certificate).

The term child includes:

a. A natural child.
b. A stepchild.
c. A legally adopted child.
d. A child for whom the covered Employee or the covered Employee's spouse has legal guardianship.
e. A child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order.
f. A dependent of a currently enrolled dependent (e.g. your grandchild). A newborn child of a *covered* dependent child is eligible from birth until the end of the month in which the child reaches 18 months of age. Otherwise, grandchildren's eligibility is contingent upon legal guardianship.

4. A child of the Employee's domestic partner through the end of the calendar year in which the child attains the age of 26 (as supported by required domestic partner documentation and child's birth certificate).
   A child of an Employee's domestic partner includes:

   a. A natural child.
   b. A legally adopted child.
   c. A child for whom the covered Employee's domestic partner has legal guardianship.
   d. A child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order.
   e. A dependent of a currently enrolled dependent (e.g. your grandchild). A newborn child of a *covered* dependent child is eligible from birth until the end of the month in which the child reaches 18 months of age. Otherwise, grandchildren's eligibility is contingent upon legal guardianship.

5. An adult child covered in 3 and 4 above may continue coverage through the end of the calendar year in which the child attains the age of 30 if the adult child meets all of the following conditions:

   a. Unmarried; and
   b. No dependent children of their own; and
   c. Full-time or part-time student or reside in the State of Florida, if not a student; and
   d. Does not have private insurance coverage and is not eligible for public insurance coverage including coverage under Title XVII of the Social Security Act.

   The premium is equal to the single adult rate for COBRA continuation coverage.

Coverage for an unmarried dependent child who is already enrolled in an OCPS medical plan and is not able to be self-supporting because of mental or physical handicap will not end just because the child has reached a certain age. Coverage will be extended beyond the limiting age for as long as the child is incapacitated and primarily dependent upon the Covered Employee for support and maintenance. Annual documentation is required.
NOTE: When a dependent is no longer eligible for coverage, it is the Employee's responsibility to contact the Insurance Benefits Office to verify that the correct amount of premium deduction is taken. Coverage will be effective upon approval and notification from OCPS.

***DOMESTIC PARTNER TAX IMPLICATIONS***

Please note, under IRS regulations, domestic partners and the children of domestic partners do not qualify as tax dependents, as a result the premiums for any plans with a domestic partner or child(ren) of a domestic partner will be deducted post-tax and the medical premiums made by OCPS on behalf of dependents will be

treated as taxable income. Examples of the impact of imputed income can be found on the Insurance Benefits intranet page at http://insurance.ocps.net. Employees should consult a tax advisor prior to adding coverage.

## *ENROLLING FOR COVERAGE*

### *Initial Enrollment*

The initial enrollment period begins when employees hired in an eligible payroll area meet all eligibility requirements. New Employee Enrollment must be completed online through Employee Self-Service within two weeks from the employee's first day of work. Full-time employees who do not make a medical plan or alternative to medical plan selection will be automatically enrolled with employee-only coverage in the Cigna Local Plus In-network plan (Plan A). Once enrolled, Employees cannot change the plan until the next Annual Enrollment.

### *Annual Enrollment*

Each year, employees have the opportunity to make changes to their benefit elections during Annual Enrollment. Current benefit elections will automatically continue unless you complete the Annual Enrollment process online. OCPS typically holds Annual Enrollment in May/June. Refer to the Plan Summaries for details on each benefit. Changes will be effective October 1st.

*Note on Flexible Spending Account Elections.* If you participate in the Flexible Spending Accounts (FSA's) you **must** make new elections annually even if you do not want to make a change. FSA elections will be effective September 1st.

### *Mid-year Changes in Enrollment*

All eligible employees and dependents, once enrolled and provided the premium is paid, cannot change their elections in the plan(s) for the remainder of the plan year except under certain circumstances as allowed by HIPAA Special Enrollment Rights or as defined in Section 125 of the Internal Revenue Code (IRC), for example:

- A change in family or employment status,
- A change in cost or coverage for certain benefits.

The change in status must result in an employee, spouse or dependent gaining or losing eligibility for coverage under a plan. Changes must be made by notifying the Insurance Benefits Office within thirty (30) days (unless time frames are specifically noted differently) of the qualifying change in status.

*Note for Newborns and Adoptions.* If notice is provided to the Insurance Benefits Office within thirty (30) days of the birth or placement for adoption, no additional premium (if applicable) will be charged for the first thirty (30) days from birth or placement for adoption. If notice is given more than thirty (30) days but within sixty (60) days of the birth or placement for adoption, you will be charged the additional premium (if applicable) from the date of birth or placement for adoption. If notice is not provided within sixty (60) days of the birth or placement for adoption, you must wait until the next Annual Enrollment or have a qualifying change in status as defined by Section 125 of the Internal Revenue Code.

Refer to Section E. the Summary Plan Description of the Orange County Public Schools Section 125 Plan for more detail.

***Note for Domestic Partners and their children***

Employees with coverage for a domestic partner and/or a domestic partner's child(ren) will have post-tax premium deductions. As such, this post-tax coverage can be dropped at any time. Mid-year changes to add a domestic partner or child(ren) of a domestic partner will follow Section 125 guidelines.

***TERMINATION OF COVERAGE***

Benefits generally end:

1. The end of the month in which employment ceases*
2. The first day of any month for which continuous premium payments are not made
3. When dependents are no longer considered eligible under these plans
   a. Grandchildren who are covered as a dependent of dependent (other than spouse/domestic partner). If the parent becomes ineligible during the grandchild's 18 months eligibility period, coverage for both the parent and the child will terminate.
4. When these plans are no longer in force.
5. When the Employee fails to provide documented proof of dependency at enrollment or when requested by the Insurance Benefits department:
   a. Coverage ends the last day of the month following 60 days from the date of notification to the Employee, by regular U.S. Mail to the Employee's last known address as shown by the records of OCPS.

*Ten-month employees who resign, retire or are non-reappointed, and completed the school year, will have coverage through the end of August.

**If you are retiring from OCPS and are interested in continuing your coverage, please contact the Insurance Benefits Office prior to your retirement date.**

***PLAN YEAR***

October 1 through September 30 of each year.

**NOTE: The plan year for Flexible Spending Accounts (FSA's) is September 1 through August 31 of each year (with a "grace period" of 2 months and 15 days following the end of the plan year).**

***LEAVE OF ABSENCE***

Coverage may be continued during an OCPS approved leave of absence. When you are no longer receiving a paycheck and payroll deductions stop, you will be billed for most of the insurance plans* (including the OCPS-paid plans).

*The Group Universal Life plan is direct-billed from the appropriate company.

***FAMILY AND MEDICAL LEAVE ACT INFORMATION***

The Family and Medical Leave Act of 1993 (FMLA) applies to all public agencies and allows eligible employees to take up to 12 weeks of leave for the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

- for any qualifying event due to the employee's spouse, son, daughter or parent being on active duty in the armed services or called to active duty in support of a war or national emergency.

An eligible employee who is a spouse, son, daughter, parent, or "next of kin" (the nearest blood relative) of a member of the armed services may take up to 26 weeks of leave during a single 12 month period to care for a member of the Armed Forces, including a member of the National Guard or Reserves who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness suffered while on active duty.

To be eligible, an employee must be employed by OCPS at least 12 months and have 1,250 hours worked in the 12 months prior to the leave.

Generally, employers covered by the FMLA are required to continue to provide the same individual group health coverage during the leave period, and once the leave period is concluded, to reinstate the employee to the same or equivalent position. In addition, the FMLA provides that an employee taking such a leave shall not lose any benefits (including retirement rights or benefits) that he or she had accrued before the leave. However no retirement credit may be earned during the time an employee is on a FMLA leave.

For questions or more details about the FMLA, please contact the Family Medical Leave Information line at 407.317.3652 (FMLA).

### *IDENTIFICATION CARDS*

The identification card (ID card) for the medical insurance plan you select will be mailed to your home address. You should present this ID card when you utilize one of the providers/services. You also will receive a separate card for your pharmacy benefit. You should present this card when you have any prescriptions filled at a retail pharmacy.

New plan ID cards are only issued if changes are made in the coverage offered. If your ID card is stolen or misplaced, please contact the appropriate carrier or administrator.

### *DISCLAIMER*

**The information contained in this handbook is a summary of the coverages for each plan. If there is a conflict between the information in this handbook and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents.**

### *OCPS EEO NON-DISCRIMINATION STATEMENT*

The School Board of Orange County, Florida, does not discriminate in admission or access to, or treatment or employment in its programs and activities, on the basis of race, color, religion, age, sex, national origin, marital status, disability, genetic information, sexual orientation, gender identity or expression, or any other reason prohibited by law. The following individuals at the Ronald Blocker Educational Leadership Center, 445 W. Amelia Street, Orlando, Florida 32801, attend to compliance matters: ADA Coordinator & Equal Employment Opportunity (EEO) Supervisor: Carianne Reggio; Section 504 Coordinator: Latonia Green; Title IX Coordinator: James Larsen. (407.317.3200)

## B. PLAN OVERVIEWS

### MEDICAL INSURANCE

One of the benefits you receive as an employee of OCPS is medical insurance, once you have satisfied the waiting period. If you are an eligible, full-time, active employee working 25 hours or more per week, a minimum of one plan is available where the Employee only rate is fully paid for you by OCPS. If you are an eligible, part-time, active employee working at least 17.5 hours per week, but less than 25 hours per week, a minimum of one plan is available where 50 percent of the Employee only rate is paid for you by OCPS. You may choose one of the options described below. Medical insurance also is available through payroll deduction for your spouse/domestic partner and/or your eligible children.

***Plan A: Cigna Local Plus OAP In-Network***
When using this plan, you can go to any provider within the network to identify, evaluate and help manage all your healthcare needs. This network is limited to specific providers in central Florida.

***Plan B: Cigna Health Reimbursement Account***
With this plan, you have the option to go to any medical person and facility. However, when choosing the providers in the network, your benefit coverage will be at a greater level than when opting to receive services outside the network.

***Plan C: Cigna OAP In-Network***
When using this plan, you can go to any provider within the network to identify, evaluate and help manage all your healthcare needs.

***Alternative to Medical Insurance***
If you have other qualifying group medical insurance (such as through your spouse) and you do not want the medical insurance offered by OCPS, you **must** select the OCPS paid alternative: Disability and vision coverage.

***Acceptance/Waiver of Medical Insurance***
If you work at least 17.5 hours per week, but less than 25 hours per week, the Board contributes 50 percent of the Employee-only medical insurance rate. Consequently, you have the option to pay the other 50 percent through payroll deduction, enroll in the Alternative to Medical Insurance plan at no cost, or decline the medical insurance.

### TERM LIFE INSURANCE

The term life insurance offered by OCPS provides life insurance protection while you are an employee. This coverage will be terminated once you leave employment with OCPS. There are two plans: One is paid for by OCPS, and the other one is available through payroll deduction.

***OCPS-Paid Life Insurance***
OCPS pays your life insurance premium for term insurance which is equal to one times your base annual salary, with a minimum of $7,500.

**The following option is available to you with the premium deducted from your paycheck:**

***Dependent Term Life Insurance***
You may purchase life insurance for your spouse/domestic partner up to $10,000 and for each child up to $5,000, depending on your annual salary. During Annual Enrollment or as a new employee, no health questions are required to be eligible for this coverage.

## GROUP UNIVERSAL LIFE INSURANCE

You may purchase additional life insurance coverage in $10,000 increments. The minimum benefit is $10,000; the maximum benefit is five times your annual salary rounded to the next higher $10,000, or $1,000,000, whichever is less. You also have the ability to make contributions to a Cash Accumulation Fund. New employees will be eligible for up to two times their annual salary rounded to the next higher $10,000 or $200,000 whichever is less without health questions. Any additional amount will be subject to health questions.

In addition, coverage for your spouse/domestic partner may be purchased in $10,000 increments to a maximum of three times your annual salary rounded to the next higher $10,000 or $100,000 whichever is less with the availability of a Cash Accumulation Fund. New employees will be eligible to purchase spouse coverage in the amount of $10,000 without health questions. Any additional amount will be subject to health questions.

A $5,000 or $10,000 term life policy may be purchased for eligible dependent children (provided you elect coverage on yourself or your spouse/domestic partner).

During this year's annual enrollment employees who are not currently enrolled in the GUL plan can enroll in $10,000 increments up to one times their basic annual earnings, rounded to the next higher $10,000 or $100,000 whichever is less without health questions. Employees who *are* currently enrolled in the GUL plan can increase coverage in $10,000 increments up to one times their annual salary rounded to the next higher $10,000 to a *new total* maximum of two times annual salary rounded to the next higher $10,000, or $200,000, whichever is less without health questions.

## DISABILITY INSURANCE

Disability insurance helps you to cover your expenses if you are not able to work due to an accident or illness. Available through payroll deduction, you can select a benefit to meet your needs.

You select the benefits from $200 to $7,500 that will replace your monthly income up to 66 2/3 percent of your salary. You also choose the waiting period, so that benefits will begin after day(s) 14, 30, 60 or 180. No health questions will be required for this year's annual enrollment or if you are a new employee enrolling during your initial enrollment period. The pre-existing limitation applies. Refer to section *V. Disability* of this handbook for pre-existing condition details.

For employees who are currently enrolled in the disability program, you may choose to increase your monthly benefit up to 66 2/3 percent of salary ($7,500 plan maximum), in $100 increments, without health questions. The pre-existing condition limitation applies to the increased amount of insurance including any reduction made to the waiting period.

Benefits begin on the day after the waiting period you have selected (14, 30, 60 or 180 days), and will continue to age 65 or Social Security Normal Retirement Age, whichever is greater, if disability begins before age 65. If disability begins after age 65 please refer to the certificate of coverage for the payment schedule.

## DENTAL INSURANCE

Dental insurance is provided to employees and dependents of OCPS through payroll deduction. OCPS provides three different options of quality dental care. You may choose from either two managed care plans or a PPO plan.

***DeltaCare® USA Basic Managed Care Dental Plan (HMO Type)***
The main focus of this plan is preventive dentistry and is designed for individuals who currently have healthy teeth and gums. You must use a participating general dentist to receive benefits. If you are referred to a

participating dental specialist (or if you refer yourself), you will receive a 25 percent reduction from usual and customary fees for services performed.

***DeltaCare® USA Comprehensive Managed Care Dental Plan (HMO Type)***
If you select this plan, you will be able to receive regular checkups, cleanings and x-rays at no charge. A benefits and copayment schedule is enclosed that shows the amount you will be responsible to pay. To be eligible for this plan, you will need to select a dentist from the enclosed list. If you are referred to a participating dental specialist, you will pay no more than what is listed in the schedule. Orthodontic care also is a covered benefit. There is little paperwork with this plan, and there are no maximum benefit restrictions with the exception of orthodontia and accidental injury to the sound natural teeth.

***Delta Dental PPO (Preferred Provider Organization) Dental Plan***
You may select any dentist you wish under this plan. However, if you choose a preferred dentist from the PPO dental plan list, you receive greater coverage and have lower out-of-pocket costs. The enclosed schedule of benefits shows the maximum amount the PPO dentist will be reimbursed for each procedure code. You will be responsible for any applicable deductible and/or coinsurance amounts. **With this plan the maximum benefit each year is $1,300.** For procedures that are not diagnostic and preventive, there is a $25 calendar year deductible (maximum $75 per family) when using the **in-network** PPO dentists and a $50 calendar year deductible (maximum $150 per family) when using the **out-of-network** dentists.

***Orthodontic Discount Program for Employees***
You and your family are eligible to receive discounts on Orthodontics through this plan. There is no monthly premium and it is not necessary to complete any enrollment forms. Upon showing proper proof that you are employed by OCPS, you and any dependent can receive the 25% discount on Orthodontics. The participating orthodontist will ask for proper proof of employment with OCPS. To receive a list of participating orthodontists, please call 407.660.9034 **and leave your name and email address**.

***Vision Discount Program for Employees***
You and your family are eligible to receive a courtesy discount on vision care up to 35%. There are no monthly premiums and it is not necessary to complete any enrollment forms.
Visit www.eyemedvisioncare.com/deltadental to print an ID card and get a list of participating EyeMed providers or call 1.866.246.9041. When scheduling your appointment, inform the office that you are an EyeMed member with a Delta Dental discount plan. Present your printed ID card at your appointment to receive discounted services.

***Plan Administration***

DeltaCare® USA Basic and Comprehensive Managed Care Plans:
Private Medical-Care, Inc.
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800.422.4234

Delta Dental PPO (Preferred Provider Organization) Plan:
Delta Dental Insurance Company
Attn: Professional Services Dept.
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
800.616.3629

## VISION INSURANCE

Being an employee of OCPS gives you the opportunity to purchase vision insurance through payroll deduction. If you select the Humana Specialty Benefits Vision Plan, you receive prepaid services for routine eye care – vision exam plus glasses (lenses and frames) or contacts – through a nationwide network, including more than 1,000 eye doctors in Florida.

## FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to make payroll deductions on a pre-tax basis to pay for certain eligible health and/or dependent care expenses. There are two types of FSAs: One is for healthcare expenses and is called a "Medical Flexible Spending Account." The other is for dependent care expenses and is called a "Dependent Care Flexible Spending Account." The accounts are treated separately – you may participate in either or both accounts, but may not transfer funds between accounts. When you enroll you designate how much you want to put into your account for the upcoming plan year. The plan is "use it or lose it." That is, if you haven't used all of the money in your Flexible Spending Accounts by the end of the plan year, you cannot carry over that money to the next year. Any unused funds will be forfeited.

Domestic partners and their children are not considered eligible dependents for purposes of FSA participation in accordance with IRS rules.

## C. FREQUENTLY CALLED PHONE NUMBERS

| | |
|---|---|
| Cigna (For All Cigna Medical Plans) | 1.800.244.6224 |
| CVS/Caremark | 1.800.378.9264 |
| DeltaCare® USA Managed Dental Plans | 1.800.422.4234 |
| Delta Dental PPO (Preferred Provider Organization) Dental Plan | 1.800.521.2651 |
| Employee Assistance Program | 407.647.1781 |
| Employee Wellness Program | 407.317.3200, Ext. 2929 |
| Humana Specialty Benefits Vision Plan | 1.800.865.3676 |
| Lincoln Financial Group Disability Plan | 1.800.423.2765 |
| Minnesota Life Insurance Group Universal Life | 1.800.843.8358 |
| OCPS Insurance Benefits Office | 407.317.3245 |
| Orlando Behavioral Healthcare | 407.637.8080 |
| Total Administration Services Corporation (TASC) | 1.800.422.4661 |

## D. WEBSITES (FOR PROVIDER DIRECTORIES)

| | |
|---|---|
| Plan A: Cigna Local Plus OAP In-Network | www.cigna.com<br>Choose ***Find A Doctor***. Click on the ***For plans offered through work or school…*** link, enter a search location, then click the down arrow at ***Select a Plan***, choose ***LocalPlus***.<br>In the ***Looking For*** box, enter the provider's name, specialty or type of service. Click ***Search***. |
| Plan B: Cigna Health Reimbursement Account | www.cigna.com<br>Choose ***Find A Doctor***. Click on the ***For plans offered through work or school…*** link, enter a search location, then click the down arrow at ***Select a Plan***, choose ***Open Access Plus, OA Plus, Choice Fund OA Plus.*** In the ***Looking For*** box, enter the provider's name, specialty or type of service. Click ***Search***.<br><br>*Please note, when looking for a specialist, the copay is reduced from $65 to $45 when you choose a **Cigna Care Designation** provider.* |
| Plan C: Cigna OAP In-Network | www.cigna.com<br>Choose ***Find A Doctor***. Click on the ***For plans offered through work or school…*** link, enter a search location, then click the down arrow at ***Select a Plan***, choose ***Open Access Plus, OA Plus, Choice Fund OA Plus.*** In the ***Looking For*** box, enter the provider's name, specialty or type of service. Click ***Search***. |
| CVS/Caremark | www.caremark.com |
| Total Administration Services Corporation (TASC) | www.tasconline.com |
| DeltaCare® USA Managed Dental Plans | www.deltadentalins.com<br>Under ***Find a Dentist***, select your plan network, ***DeltaCare USA*** (for the DeltaCare Basic or Comprehensive plans). Select your state, then your city or zip code. |
| Delta Dental PPO (Preferred Provider Organization)Dental Plan | www.deltadentalins.com<br>Under ***Find a Dentist***, select your plan network, ***Delta Dental PPO***. Select your state, then your city or zip code. |
| Humana Specialty Benefits Vision Plan | www.humanavisioncare.com<br>Select ***HumanaVision VCP provider locator***. Enter your address or zip code. Click ***Search***. |

## E. SUMMARY PLAN DESCRIPTION OF THE ORANGE COUNTY PUBLIC SCHOOLS SECTION 125 PLAN

Plan Name: The Cafeteria Plan of the School Board of Orange County

Plan Type: Premium Conversion Plan

Effective Date of the Plan: April 1, 1989

Company, Plan Sponsor, and Plan Administrator: The School Board of Orange County, Florida

Address: 445 W. Amelia Street, Orlando, FL 32801

Phone Number: 407.317.3200

Employer Identification Number: 59-6000771 Plan Number: 502

The Plan Administrator is designated as the agent for all purposes of legal process.

1. What is the Section 125 Plan?

   a. The OCPS Section 125 Plan, officially known as The Cafeteria Plan of the School Board of Orange County, allows you to purchase certain optional insurance coverage with pre-tax dollars. Federal income tax and social security taxes are not deducted from the amount you pay in premiums on a pre-tax basis under the Section 125 Plan. Your take home pay will be higher by participating in the Section 125 Plan compared to purchasing the same insurance coverage with after tax dollars.

      **Federal Tax Implications for Dependent Coverage**

      Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance that does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

2. What benefits are available to me?

   a. Under the Section 125 Plan the following optional insurance benefits are available to you:

      (1) Medical Insurance
          (a) Dependent
          (b) Part-time employee
      (2) Term Life Insurance up to $50,000
      (3) Dental Insurance
      (4) Vision Insurance
      (5) Flexible Spending Accounts

b. Each insurance benefit that is offered under the plan is explained in separate sections of the OCPS Handbook. Additional information is available through the OCPS Insurance Benefits Office.

c. OCPS has the right to terminate, suspend, withdraw or modify the plan benefits at any time, subject to the provisions of the insurance contracts which provide these benefits. Any failure of insurance benefits, whether due to OCPS's negligence, gross neglect, or otherwise, including failure to enroll a participant or pay premiums, shall not result in any liability by OCPS to a participant.

d. Your coverage terminates when you leave employment, if you are no longer eligible under the terms of any insurance policy, or when insurance coverage terminates, whichever happens first.

e. Any benefits provided by insurance shall be provided only after (1) you have given OCPS the necessary information to apply for insurance, and (2) the insurance is in effect for you. Full-time employees who do not make a medical plan or alternative to medical plan selection will be automatically enrolled with employee-only coverage in the Cigna Local Plus In-network plan (Plan A). Once enrolled, Employees cannot change the plan until the next Annual Enrollment.

3. How do I join?

a. You may join the Section 125 Plan on the date you become eligible to participate in the optional insurance benefits available to you under the Section 125 Plan. You will automatically be enrolled in the Section 125 Plan unless you complete the enrollment process on Employee Self-Service and deselect the "Pre-Tax Deductions" box in each of the eligible plans to decline the Section 125 Plan.

b. You may also join or terminate from the Section 125 Plan during the Annual Enrollment period that is held no later than thirty (30) days before the start of the Plan Year.

4. How does the Section 125 Plan work once I join?

a. Your decision to participate in the Section 125 Plan cannot be changed during the Plan Year except under certain circumstances as allowed by the Internal Revenue Code (IRS) and permitted by the Section 125 Plan, such as

1. a change in family or employment status,
2. a change in cost or coverage for certain benefits, or
3. a change that gives rise to special enrollment rights under HIPAA.

The change in status must result in an employee, spouse or dependent gaining or losing eligibility for coverage under a plan. See below for details.

b. Your share of the premiums for the eligible optional insurance benefits you selected will be deducted from your paycheck before federal taxes are taken. The amount of reduced compensation is equal to your share of the premiums charged in your share of the cost.

c. If you do not complete the enrollment process through Employee Self-Service during the Annual Enrollment period, you will automatically be enrolled for the next plan year (This does not apply to the Flexible Spending Accounts. You must enroll each year).

5. Can I change my insurance benefit elections during the plan year?

a. No, you cannot change your insurance benefit elections during the plan year; however, there is an exception for a documented change in status as allowed under Section 125 of the Internal Revenue Code.

(1) You may add coverage for the following reasons: (generally within 30 days of the qualifying event, unless otherwise noted)

- Marriage/Divorce
- Death of a spouse if coverage is lost under spouse's plan
- Birth, adoption of a child or placement for adoption
- Court Order, Judgment or Decree affecting a dependent child
- Change in employment status of the employee resulting in the eligibility for coverage (i.e. increase in work hours, switch between part-time and full time or return from an unpaid leave of absence)
- Change in employment status of the employee's spouse or the employee's dependent resulting in a loss of coverage under another group plan (i.e. termination of employment, a strike or lockout, commencement of an unpaid leave of absence, reduction in work hours)
- An event that causes an employee's dependent child to satisfy eligibility requirements for coverage, such as, due to the student status or change in parental support and maintenance
- The entire COBRA coverage period has been exhausted
- No longer reside, live or work in the other plan's HMO service area that affects eligibility for coverage under the HMO, and no other coverage is available under the other plan
- If you or your dependent's coverage is terminated in your dependent's other plan during the Annual Enrollment period when the other coverage is on a different plan year
- Loss of eligibility resulting in a loss of coverage under Medicare, educational institution, medical care program of an Indian Tribal government, foreign government group health plan or a State health benefits risk pool.
- Loss of eligibility resulting in a loss of coverage under Medicaid or a State Children's Health Insurance program ("CHIP") if you request enrollment within 60 days after the date you lose eligibility.
- You and/or your dependents become eligible under Medicaid or a CHIP plan for assistance with respect to paying for premiums under the plan if you request enrollment within 60 days after you become eligible for such premium assistance.
- Loss of Marketplace eligibility because the insurer dropped the individual product line, dropped a specific plan design (e.g. HDHP, PPO, HMO), dropped out of the individual market in a state or the insurer stops offering the product at the end of the year. Loss of eligibility due to nonpayment of individual policy premiums and loss of individual coverage due to fraud do not apply.

(2) You may drop coverage for the following reasons: (Within 30 days of the change becoming effective)

- Divorce/Marriage
- Death of a dependent
- Court Order, Judgment or Decree that requires the spouse, former spouse or other individual to provide coverage for a dependent child

- Commencement of a dependent's employment that results in eligibility for coverage with his/her employer
- Dependent is newly eligible for group health plan coverage through his/her employer or college-student insurance.
- An event that causes an employee's dependent child to cease to satisfy the requirements for coverage, such as, due to the attainment of age, student status or change in parental support and maintenance
- Change in employment status resulting in a loss of eligibility for coverage (i.e. termination of employment, change in work schedule, reduction of hours, commencement of an unpaid leave of absence)
- If you or your covered dependents enroll for coverage in another plan provided by his/her employer during the Annual Enrollment period when the other coverage is on a different plan year
- Entitlement to a Government Program (Medicaid or Medicare)
- As a result of a Court Order, Judgment or Decree affecting a dependent child, if the spouse, former spouse or other individual in fact provides the required coverage for a dependent child
- Enrollment in a Qualified Health Plan (QHP) during the Marketplace annual open enrollment – The end of OCPS coverage must correspond with the enrollment in a QHP through the Marketplace. Coverage under the Marketplace QHP must be effective no later than the day immediately following the last day OCPS coverage ends.

b. In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a "change in status" if your dependent no longer meets the qualifications to be eligible for dependent care.

c. There are detailed rules on when a change in election is deemed to be consistent with a "change in status." In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Insurance Benefits Office.

d. If the cost of a benefit provided **under the Plan** increases or decreases significantly during a Plan Year, you are permitted to make a mid-year election change. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or elect coverage under another benefit package option with similar coverage, or revoke your election entirely if no similar plan is available. If the cost decreases significantly, you will be permitted to either make the corresponding changes in your payments, switch to this lower cost plan from a more costly plan option or elect this coverage if previously not enrolled.

e. If you have a significant curtailment of coverage during a Plan Year, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally. For example, there is a significant increase in the deductible, the copayment and the out of pocket cost sharing limit. If you lose coverage due to the elimination of an existing benefits package option during a Plan Year, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage or drop coverage if no similar benefit package option is available. In addition, if we add a new coverage option or significantly improve an existing benefit package option, you may elect to receive, on a prospective basis,

coverage under the new or improved benefit package option (whether or not you have previously elected coverage under the plan).

f. If your spouse or dependent has a significant curtailment of coverage and no other plan with similar coverage is offered in another plan during a Plan Year, then you may revoke your elections and elect, on a prospective basis, to add your spouse and/or dependents to your existing coverage. Coverage under another plan is significantly curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally and no similar benefit option is available. For example, there is a significant increase in the deductible, the copayment and the out of pocket cost sharing limit. In addition, if your spouse and/or dependent loses coverage due to the elimination of an existing benefits package option (with no similar coverage available) during a Plan Year, then you may revoke your elections and elect, on a prospective basis, to add your spouse and/or dependents to your existing coverage.

g. These rules on change due to cost or coverage do not apply to the Medical Flexible Spending Account, and you may not change your election to the Medical Flexible Spending Account if you make a change due to cost or coverage for insurance.

h. You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

i. Any new election will be effective at the time OCPS prescribes. The revocation and new benefit election must be consistent with the respective insurance benefit plan limitations and requirements.

j. You are required to contact the Insurance Benefits office, provide documented proof of the status change and complete the add/drop process in Employee Self-Service. Proof of the status change must be provided within thirty (30) days of the qualifying event that caused the family status change.

k. Elections made under this Plan will automatically terminate on the date you cease to be a participant in the Plan.

6. <u>How will the Section 125 Plan affect my social security and retirement benefits?</u>

a. Selection of tax-free benefits under the Section 125 Plan will normally result in you and OCPS making lower contributions to the federal Social Security System. This could reduce your benefits. In addition, other benefits based on taxable compensation could be reduced.

b. Your Florida Retirement System benefits are not affected.

7. <u>How do I claim my rights under the Section 125 Plan</u>?

a. If you believe you are being denied any rights or benefits under the Section 125 Plan, you may file a claim in writing with OCPS. If the claim is wholly or partially denied, OCPS will notify you of the decision in writing. The notification will contain the following:
(1) Specific reasons for the denial;
(2) Specific reference to pertinent plan provisions;
(3) A description of any additional material or information necessary for you to perfect such claim and an explanation of why the material or information is necessary; and
(4) Information of the steps to take if you wish to submit a request for review.

b. This notification will be given within 30 days after the claim is received by OCPS (or within 45 days, if special circumstances require an extension of time for processing the claim). If notification is not given within these periods, the claim will be considered denied as of the last day of the period and you may request a review of your claim.

c. Within 180 days after you receive written notice of a denied claim (or, if applicable, within 180 days after the denial is considered to have occurred), you (or your duly authorized representative) may;
   (1) file a written request with OCPS for a review of your denied claim and of pertinent documents; and
   (2) submit written issues and comments to OCPS.

d. OCPS will notify you of its final decision in writing. This notification will contain specific reasons for the decision as well as specific references to pertinent plan provisions. The decision will be made within 60 days after the request for review is received by OCPS. If the decision regarding the review is not made within such period, the claim will be considered denied.

## F. CONTINUATION OF HEALTH COVERAGE INFORMATION

The Department of Labor requires all employees and spouses who are newly covered by the OCPS medical plan, dental and vision to receive this initial notice of COBRA rights. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

***What is COBRA Continuation Coverage?***

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

***When is COBRA Coverage Available?***
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after OCPS, or the designated COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify OCPS or the designated COBRA Administrator of the qualifying event.

***You Must Give Notice of Some Qualifying Events***
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify OCPS or the designated COBRA Administrator within 60 days after the qualifying event occurs. You must provide this notice to: OCPS or the designated COBRA Administrator.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

***Disability extension of 18-month period of continuation coverage***

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

***Second qualifying event extension of 18-month period of continuation coverage***

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

***If You Have Questions***

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov.ebsa (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

***Keep Your Plan Informed of Address Changes***

In order to protect your family's rights, you should keep OCPS or the designated COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to OCPS or the designated COBRA Administrator.

**Plan Information**

OCPS Insurance Benefits
445 W. Amelia Street, Orlando, FL 32801
407.317.3245

**COBRA Information**

Total Administration Services Corporation (TASC)
1350 Division Road Suite 301
West Warwick, Rhode Island 02893
1.800.720.4460

Please note domestic partners and their children are not considered eligible dependents for continuation of coverage through COBRA in accordance with IRS rules.

## G. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Medical Indemnity Plan of the Orange County Public Schools (the "Plan") will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Notice of Privacy Practices for the Plan is found in Section H.

***PAYMENT FOR HEALTH CARE***

*Payment* includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, without limitation, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim).

2. Coordination of benefits.

3. Adjudication of health benefit claims (including appeals and other payment disputes).

4. Subrogation of health benefit claims.

5. Establishing employee contributions.

6. Adjusting amounts due based on enrollee health status and demographic characteristics.

7. Billing, collection activities and related health care data processing.

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments.

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).

10. Medical necessity reviews or appropriateness of care or justification of charges reviews.

11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review.

12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name, address, date of birth, Social Security number, payment history, account number, name and address of the provider and/or health plan).

13. Reimbursement to the Plan.

***HEALTH CARE OPERATIONS***

*Health Care Operations* include, without limitation, the following activities:

1. Quality assessment.

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions.

3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities.

4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance).

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies.

7. Business management and general administrative activities of the Plan, including, without limitation:

    a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or

    b. Customer service, including the provision of data analyses for policyholders, Plan sponsors or other customers.

8. Resolution of internal grievances.

9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity under HIPAA.

***THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFICIARY***

With an authorization, the Plan will disclose PHI to the Disability Insurance Plan or any other benefit plan of Orange County Public Schools that requires PHI as a prerequisite to obtain benefits for purposes related to administration of those plans.

***ORANGE COUNTY PUBLIC SCHOOLS IS THE PLAN SPONSOR***

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions and conditions outlined below.

***WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS***

The Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by HIPAA.

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual.
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual.

5. If it becomes aware, report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures as permitted by HIPAA.

6. Make PHI available to an individual in accordance with HIPAA's access requirements.

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.

8. If requested by an individual, make available the information required to provide an accounting of disclosures in accordance with HIPAA.

9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the United States Department of Health and Human Services' Secretary for the purpose of determining the Plan's compliance with HIPAA.

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction impracticable).

***ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR MUST BE MAINTAINED***

In accordance with HIPAA, only the following employees or classes of employees of Orange County Public Schools may be given access to PHI:

1. Sr. Director of Risk Management.
2. Staff designated by the Risk Manager.

### *LIMITATIONS OF PHI ACCESS AND DISCLOSURE*

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

### *NONCOMPLIANCE ISSUES*

If the persons described above do not comply with this policy, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

## H. HEALTH INSURANCE "REQUIRED DISCLOSURES AND NOTICES"

### *NOTICE OF PRIVACY PRACTICES*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS EFFECTIVE OCTOBER 1, 2008.**

If you have questions about this notice, please contact the Sr. Director, Risk Management at 407.317.3245.

### *WHO WILL FOLLOW THIS NOTICE?*

This notice describes the medical information practices of the Medical Indemnity Plan of the Orange County Public Schools (the "Plan") and that of any third party that assists in the administration of Plan claims.

### *OUR PLEDGE REGARDING MEDICAL INFORMATION*

The Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. The Plan creates a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records the Plan maintains. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which the Plan may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

The Plan is required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

### *HOW THE PLAN MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU*

The following categories describe different ways that the Plan uses and discloses medical information. For each category of uses or disclosures the Plan will explain what the Plan means and present some examples. Not every use or disclosure in a category will be listed. All of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

***For Treatment (as described in applicable regulations)***
The Plan may use or disclose medical information about you to facilitate medical treatment or services by providers. The Plan may disclose medical information about you to providers including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

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

***For Health Care Operations (as described in applicable regulations).***
The Plan may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities, underwriting, premium rating, and other activities relating to Plan coverage, submitting claims for stop-loss (or excess loss) coverage, conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs, business planning and development such as cost management; and business management and general Plan administrative activities.

***As Required By Law***
The Plan will disclose medical information about you when required to do so by federal, state or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

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

***SPECIAL SITUATIONS***

***Disclosure to Health Plan Sponsor***
Information may be disclosed to another health plan maintained by the Plan Sponsor for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to the Plan Sponsor solely for purposes of administering benefits under the Plan.

***Organ and Tissue Donation***
If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

***Military and Veterans***
If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

***Workers' Compensation***
The Plan may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

***Public Health Risks***
The Plan may disclose medical information about you for public health activities. These activities generally include the following:

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

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

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

***Law Enforcement***
The Plan may release medical information if asked to do so by a law enforcement official:

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

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

***National Security and Intelligence Activities***
The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

***Inmates***
If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary:

a. for the institution to provide you with health care:
b. to protect your health and safety or the health and safety of others, or
c. for the safety and security of the correctional institution.

***YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU***

You have the following rights regarding medical information the Plan maintains about you:

***Right to Inspect and Copy***
You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Sr. Director, Risk Management at 407.317.3245. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request.
The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

***Right to Amend***
If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.
To request an amendment, your request must be made in writing and submitted to the Sr. Director, Risk Management. In addition, you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

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

***Right to an Accounting of Disclosures***
You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to the Sr. Director, Risk Management. Your request must state a time period which may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. **For additional lists**, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

***Right to Request Restrictions***

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

The Plan is not required to agree to your request.

To request restrictions, you must make your request in writing to the Sr. Director, Risk Management. In your request, you must tell us:

a. what information you want to limit;
b. whether you want to limit our use, disclosure or both; and
c. to whom you want the limits to apply, for example, disclosures to your spouse.

***Right to Request Confidential Communications***

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

To request confidential communications, you must make your request in writing to the Sr. Director, Risk Management. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

***Right to Receive Notification of any Security Breaches***

If the Plan has any unsecured protected health information about you, and that unsecured information is accessed, acquired or disclosed by or to an unauthorized person, you have the right to receive notification about such security breach. The Plan will abide by breach notification requirements under the law.

***A Note About Personal Representatives***

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

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

***Right to a Paper Copy of This Notice***

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site, http://Insurance.ocps.net. To obtain a paper copy of this notice, contact the Sr. Director, Risk Management at 407.317.3245.

***Changes to This Notice***
The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for medical information the Plan already has about you as well as any information The Plan receives in the future. The Plan will post a copy of the current notice on the OCPS Intranet. The notice will contain on the first page, in the top right-hand corner, the effective date.

***Complaints***
If you believe your privacy rights have been violated you may file a complaint with the Plan. To file a complaint with the Plan, contact the Sr. Director, Risk Management at 407.317.3245. All complaints must be submitted in writing. In addition to filing a complaint with the Plan you may file a complaint with the Secretary of the Department of Health and Human Services.

Region IV, Office for Civil Rights, U.S. Department of Health and Human Services,
Atlanta Federal Center,
Suite 3B70, 61 Forsyth Street, SW.,
Atlanta, GA 30303-8909.
Voice Phone 404.562.7886 FAX 404.562.7881 TDD 404.331.2867

For all complaints filed by e-mail send to: OCRComplaint@hhs.gov. You will not be penalized for filing a complaint.

***Other Uses of Medical Information***
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures the Plan has already made with your permission, and that the Plan is required to retain our records of the care that the Plan provided to you.

***INITIAL NOTICE REGARDING HIPAA'S SPECIAL ENROLLMENT PROVISION***

A federal law called HIPAA requires that we notify you about your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

***Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)***
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

***Loss of Coverage For Medicaid or a State Children's Health Insurance Program***
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

***New Dependent by Marriage, Birth, Adoption, or Placement for Adoption***
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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

***Eligibility for Medicaid or a State Children's Health Insurance Program (CHIP)***
If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption.

Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

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

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

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

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

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

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | FLORIDA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Website: http://flmedicaidtplrecovery.com/hipp/<br>Phone: 1-877-357-3268 |

| ALASKA – Medicaid | GEORGIA – Medicaid |
|---|---|
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: http://dch.georgia.gov/medicaid<br>- Click on Health Insurance Premium Payment (HIPP)<br>Phone: 404-656-4507 |
| **ARKANSAS – Medicaid** | **INDIANA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.hip.in.gov<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com<br>Phone 1-800-403-0864 |
| **COLORADO – Medicaid** | **IOWA – Medicaid** |
| Medicaid Website: http://www.colorado.gov/hcpf<br>Medicaid Customer Contact Center: 1-800-221-3943 | Website: http://www.dhs.state.ia.us/hipp/<br>Phone: 1-888-346-9562 |

| KANSAS – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Website: http://www.kdheks.gov/hcf/<br>Phone: 1-785-296-3512 | Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf<br>Phone: 603-271-5218 |
| **KENTUCKY – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: http://chfs.ky.gov/dms/default.htm<br>Phone: 1-800-635-2570 | Medicaid Website:<br>http://www.state.nj.us/humanservices/<br>dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **LOUISIANA – Medicaid** | **NEW YORK – Medicaid** |
| Website:<br>http://dhh.louisiana.gov/index.cfm/subhome/1/n/331<br>Phone: 1-888-695-2447 | Website: http://www.nyhealth.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MAINE – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Website: http://www.ncdhhs.gov/dma<br>Phone: 919-855-4100 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NORTH DAKOTA – Medicaid** |
| Website: http://www.mass.gov/MassHealth<br>Phone: 1-800-462-1120 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **MINNESOTA – Medicaid** | **OKLAHOMA – Medicaid and CHIP** |
| Website: http://mn.gov/dhs/ma/<br>Phone: 1-800-657-3739 | Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |

| MISSOURI – Medicaid | OREGON – Medicaid |
|---|---|
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 |
| **MONTANA – Medicaid** | **PENNSYLVANIA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 | Website: http://www.dhs.pa.gov/hipp<br>Phone: 1-800-692-7462 |
| **NEBRASKA – Medicaid** | **RHODE ISLAND – Medicaid** |
| Website:<br>http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx<br>Phone: 1-855-632-7633 | Website: http://www.eohhs.ri.gov/<br>Phone: 401-462-5300 |
| **NEVADA – Medicaid** | **SOUTH CAROLINA – Medicaid** |
| Medicaid Website: http://dwss.nv.gov/<br>Medicaid Phone: 1-800-992-0900 | Website: http://www.scdhhs.gov<br>Phone: 1-888-549-0820 |

| SOUTH DAKOTA - Medicaid | WASHINGTON – Medicaid |
|---|---|
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program<br>Phone: 1-800-562-3022 ext. 15473 |
| **TEXAS – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website:<br>http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx<br>Phone: 1-877-598-5820, HMS Third Party Liability |
| **UTAH – Medicaid and CHIP** | **WISCONSIN – Medicaid and CHIP** |
| Website:<br>Medicaid: http://health.utah.gov/medicaid<br>CHIP: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 | Website:<br>https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf<br>Phone: 1-800-362-3002 |
| **VERMONT– Medicaid** | **WYOMING – Medicaid** |
| Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 | Website: https://wyequalitycare.acs-inc.com/<br>Phone: 307-777-7531 |
| **VIRGINIA – Medicaid and CHIP** | |
| Medicaid Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>CHIP Phone: 1-855-242-8282 | |

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

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

***NEWBORNS AND MOTHERS HEALTH PROTECTION ACT***

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

***WOMAN'S HEALTH AND CANCER RIGHTS***

On October 21, 1998, Congress passed a bill called the *Women's Health and Cancer Rights Act*. This new law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymphedemas

In addition, the plan may not:

- interfere with a woman's rights under the plan to avoid these requirements, or
- offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan. If you have questions about the current plan coverage, please contact Cigna.

***QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)***

***Eligibility for Coverage under a QMCSO***
If a Qualified Medical Child Support Order (QMCSO) or Order is issued for your child, that child will be eligible for coverage as required by the QMCSO and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

***Qualified Medical Child Support Order Defined***
A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the Order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the Order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the Order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the Order states the period to which it applies; and
5. if the Order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an Order may require a plan to comply with State laws regarding health care coverage.

***Payment of Benefits***
Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

***COVERAGE OF STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE (MICHELLE'S LAW)***

If your Dependent child is covered by the medical plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)
Coverage will terminate on the earlier of:

a) The date that is one year after the first day of the medically necessary leave of absence; or
b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A "medically necessary leave of absence" is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

***NOTICE OF FEDERAL REQUIREMENTS UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)***

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical, dental and vision coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

***Continuation of Coverage***
For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

***Reinstatement of Benefits (applicable to all coverages)***
If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

***NOTICE OF OPT-OUT STATUS FOR MENTAL HEALTH SERVICES***

The Health Insurance Portability and Accountability Act (HIPAA) requires that Mental Health benefits be administered in the same manner as both medical and surgical benefits, but allows self-funded non-federal governmental group plans to opt out of this requirement.

The Mental Health benefit currently offered to OCPS members affords all members initial access to counseling at no cost to them. If OCPS opts in and changes the plan to mirror medical and surgical benefits that would mean that copayments/coinsurance would be charged at the same rate as Primary Care Physician and Specialist visits and inpatient hospitalization, which would not be in the best interest of employees/dependents.

Since OCPS administers a self-funded non-federal governmental group plan and has the option to opt out of the requirements of the Mental Health Parity Act, OCPS has determined to do so. OCPS will continue to offer mental health benefits to its employees and dependents covered under the healthcare plan in the same manner as it always has.

OCPS is required to provide the following notice to its members as notice of opt-out status.

## *NOTICE TO ENROLLEES IN A SELF-FUNDED NON-FEDERAL GOVERNMENTAL GROUP HEALTH PLAN*

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Orange County Public Schools Benefits Trust has elected to exempt the Mental Health benefit provided through Orlando Behavioral Health associated with all plans for healthcare provided by Orange County Public Schools Benefits Trust from the following requirement:

Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plans.

The exemption from these Federal requirements was initially in effect for 2010-2011 plan year beginning October 1, 2010 and ending September 30, 2011, continued through the 2011-2012, 2012-2013, 2013-2014, 2014-2015, 2015-2016, 2016-2017 plan years and is being renewed for the subsequent 2017-2018 plan year beginning October 1, 2017 and ending September 30, 2018. The election may be renewed for subsequent plan years.

Questions about this Notice should be directed to the Sr. Director, Risk Management, Orange County Public Schools, 445 W. Amelia St., Orlando, FL 32801, or by telephone at 407.317.3245.

## *OCPS GRIEVANCE PROCEDURE*

A grievance is a formal complaint filed by a Covered Person. The OCPS Grievance Procedure follows a confidential method of hearing and resolving grievances involving interpretations of the Plan. Find the OCPS Grievance Procedure on the OCPS Intranet at http://insurance.ocps.net.

# I. PLAN ADMINISTRATION

Name of Plan:

The Medical Indemnity Plan of the Orange County Public Schools
Employer whose employees are covered by the Plan (the "Employer"):
The School Board of Orange County, Florida

Policy Number: 08001 I.R.S. Employer Identification No. of sponsor of the Plan: 59-6000771

Plan number assigned by sponsor of the Plan: 502

Plan Administrator:

Orange County Public Schools, Senior Director, Risk Management
445 W. Amelia St.
Orlando, FL 32801
407.317.3245

Name and address of agent for service of legal process:

Dr. Barbara Jenkins, Superintendent
Orange County Public Schools
P. O. Box 271, Orlando, FL 32802

(Service of legal process may also be made upon the plan administrator).

The general administration of this plan is provided by the third party administrator contracted to handle certain administrative responsibilities and to process claims:

Cigna Health Plans
Hamilton Village Claim Office
P.O. Box 182223
Chattanooga, TN 37422-7223
1.800.244.6224

CVS/Caremark
One CVS Drive
Woonsocket, RI 027895
1.800.378.9264

Orlando Behavioral Healthcare
260 Lookout Place, Suite 202
Maitland, FL 32765
407.637.8080

Covered employees contribute toward the cost of coverage through payroll deductions or salary reduction through the Section 125 plan. All other contributions are provided by the employer. All benefits are funded through the School Board of Orange County, Florida, Employee Benefits Trust with the majority of assets held at Wells Fargo of Orlando. Investment instruments may be made through other institutions as appropriate. Name and title for the Trustees of the Trust are as follows:

Dr. Barbara Jenkins, Superintendent
Orange County Public Schools

Dr. Karen van Caulil, President
Florida Health Care Coalition

Meredith Robertson, Consultant
University of Central Florida

Richard Collins, Consultant
Orange County Public Schools

Dale Kelly, Chief Financial Officer
Orange County Public Schools

Trustees can be reached at Orange County Public Schools, P.O. Box 271, Orlando, FL 32802.

# II. MEDICAL INSURANCE

**A. Plan A: Cigna Local Plus In-Network**

## II. MEDICAL INSURANCE

## A. Plan A: Cigna Local Plus In-Network

### OVERVIEW

Cigna Health Care LocalPlus In-Network is designed to provide the highest quality healthcare while maintaining your freedom to choose from a local selection of personal physicians. You have the option to choose a Primary Care Physician (PCP) who specializes in one of these areas: family practice, internal medicine, general medicine or pediatrics. Your PCP or personal physician can be a source for routine care and for guidance if you need to see a specialist or require hospitalization. If you see a provider who is not in the LocalPlus Network, your plan does not cover those services, except in emergencies.

To access an online provider directory for these plans visit www.cigna.com, choose "Find A Doctor," choose "LocalPlus ONLY." For detailed instructions in using the provider directory, please see page 11 of the *General Insurance Information* section of this handbook.

Cigna Health Care LocalPlus In-Network provides well-managed services to deliver cost effective, quality care through the physicians' private offices and facilities. To ensure full and proper medical treatment, and reduce unnecessary procedures, this program emphasizes pre-admission screening, prior authorization for specific services, ambulatory services, home healthcare, and preventive care.

Please use the Summary of Benefits and Coverage as a guide to your plan. This schedule does not contain all provisions of your benefit plan.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For in-network providers: $250/individual or $500/family<br><br>Does not apply to in-network preventive care, immunizations, mental health services, substance abuse services, and prescription drugs.<br>Co-payments don't count toward the deductible.<br>Deductible amounts met in July, August, September apply to current plan year and following plan year | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. In-network preventive care & immunizations, mental health services, substance abuse services, prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | For in-network providers $5,000/individual or $10,000/family<br>For in-network prescription drugs - $1,000/person or $2,000/family<br>For in-network Mental Health/Substance Abuse - $500/person or $1,000/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| Will you pay less if you use a network provider? | Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays ( balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $20 copay/visit | Not covered | None |
| | Telehealth | $10 copay/visit | Not Covered | None |
| | Specialist visit | $35 copay/visit | Not covered | None |
| | Preventive care/ screening/ immunization | No charge/visit**<br>No charge/screening **<br>No charge/immunizations**<br><br>**Deductible does not apply | Not covered | None<br><br>You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | Plan pays 100% | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $100 copay per type of scan/day, plan pays 100% | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.caremark.com | Generic drugs (Tier1) | $7 co-pay/retail 30-day prescription<br>$14 co-pay/CVS/Caremark mail order or CVS Retail 90-day prescription<br>$21 co-pay/retail 90-day prescription | Not covered | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| | Preferred brand drugs (Tier 2) | 10% co-insurance (min.$40): retail 30-day prescription<br>10% co-insurance (min. $80): CVS/Caremark mail order or CVS Retail 90-day prescription<br>10% co-insurance (min. $120): retail 90-dayprescription | Not covered | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| | Non-preferred brand drugs (Tier 3) | Not Covered | Not covered | See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| | Covered medications more than $1,500 for a 30-day supply | 10% co-insurance (min. $75): retail 30-day prescription<br>10% co-insurance (min. $150): CVS/Caremark mail order or CVS Retail 90-day prescription<br>10% co-insurance (min. $225): retail 90-day prescription | Not covered | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery | 10% coinsurance | Not covered | None |
| | Physician/surgeon fees | 10% coinsurance | Not covered | None |
| If you need immediate medical attention | Emergency room care | $300 copay/visit | $300 copay/visit | Per visit copay is waived if admitted |
| | Emergency medical | 10% coinsurance | 10% coinsurance | None |
| | Urgent care | $35 copay/visit | $35 copay/visit | Per visit copay is waived if admitted |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | Not covered | None |
| | Physician/surgeon fees | 10% coinsurance | Not covered | None |
| If you need mental health, behavioral health or substance abuse services please contact: Orlando Behavioral Healthcare at 407.637.8080 | The schedule for behavioral/mental health services is outlined in Section II. E. | | | |
| If you are pregnant | Office Visits | $20 PCP or $35 Specialist Copay | Not covered | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.<br>Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | $150 copay, plus 10% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 10% coinsurance | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | <br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you need help recovering or have other special health needs | Home health care | Plan pays 100% | Not covered | Coverage is limited to 100 days in-network annual max. 16 hour maximum per day |
| | Rehabilitation services | $25 copay/visit | Not covered | Coverage is limited to annual max of: 50 days for Pulmonary Rehab, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic Care and Cardiac Rehab. |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | 10% coinsurance | Not covered | Coverage is limited to 120 days annual max. |
| | Durable medical equipment | Plan pays 100% | Not covered | None |
| | Hospice services | 10% coinsurance | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Children)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Eye care (Adult & Children)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids ($3,000 maximum per 36 months)
- Private Duty Nursing

# About these Coverage Examples:

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

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

- The plan's overall deductible $250
- Specialist copayment $35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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

| Total Example Cost | $12,800 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $190 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| The total Peg would pay is | $1,550 |

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

- The plan's overall deductible $250
- Specialist copayment $35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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

| Total Example Cost | $7,400 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $900 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| The total Joe would pay is | $1,400 |

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

- The plan's overall deductible $250
- Specialist copayment $35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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

| Total Example Cost | $1,900 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $400 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $750 |

## Plan A: Cigna Local Plus In-Network
## PRECERTIFICATION/UTILIZATION MANAGEMENT

The precertification/utilization management process ensures that you, as the patient, are receiving medical care and treatment that is appropriate, medically necessary and being performed in the best setting.

Therefore, if your physician recommends **hospitalization, outpatient surgery or defined procedures/services as listed below,** for you or your eligible dependent, **precertification** is required by **your physician for in-network services and by you and/or your physician for out of network services** by calling 1.800.CIGNA24 (1.800.244.6224) five (5) days prior to services being rendered. You **must** receive services from an in-network provider in order to receive your highest level of benefit reimbursement. You will receive a letter stating what services and/or treatments have been approved.

If your hospitalization is for a maternity stay, no authorization is required for a 48 hour stay for vaginal deliveries or a 96 hour stay for Cesarean section. Longer stay must be authorized by Cigna Health Care.

If admission is due to an emergency, you or a member of your family, and your physician must call Cigna Health Care at 1.800.CIGNA24 (1.800.244.6224) within 48 hours or as soon as possible. All emergency admissions will be reviewed for medical necessity.

Concurrent review will be performed during your hospital stay to ensure that continued hospitalization is warranted. You will be visited by a Cigna Health Care nurse to assist with any discharge needs you may have.

Precertification is required for **ALL** in-patient admissions, and the following list of services and procedures whether performed in a hospital, outpatient facility, or doctor's office:

- All elective and urgent/emergent admissions, observation stays, skilled nursing facility, rehab facilities, hospice facilities, and transfers between facilities.
- Any covered dental-treatments and procedures including, but not limited to: orthognathic procedures, TMJ procedures, procedures to treat injury to sound natural teeth.
- MRA, MRI, CT, and PET Scans
- Durable medical equipment
- Devices including, but not limited to: cochlear implants, insulin pumps
- Home health care and home infusion therapy
- Tonsillectomy – in-patient only
- Uvulopharyngopalatoplasty – in-patient only
- Hysterectomy
- Speech therapy, prior to the first visit

**Please note: List of services is subject to change without notice. When precertifying procedures, all claims are subject to retrospective review, if necessary, to confirm that procedures or services are covered and not excluded under the Plan Document.**

**Serious Illness**

If you or a covered family member ever need care beyond a traditional hospital stay, Cigna Health Care Case Management service provides valuable counseling, support and care coordination. An experienced case manager, assigned specifically to your situation, works closely with your doctor to help you sort out your options, contact facilities, arrange care, and access helpful community resources and programs.

For more information call Customer Service at the toll-free number on your Cigna Health Care ID card, 1.800.CIGNA24 (1.800.244.6224).

**The Cigna Health Care Your Health First Program**

Your Cigna Health Care plan includes the Cigna Health Care Your Health First Program for better health. It offers valuable, confidential support for you and your covered family members with specific medical conditions. The Cigna Health Care Your Health First Program provides educational materials that help you learn more about your health condition, regular reminders of important checkups and tests and helpful information that keeps your doctor advised of the latest care and treatment techniques.

The Cigna Health Care Your Health First Program helps you and your doctor follow your condition more closely and treat it more effectively.

The following programs are available:

- Asthma
- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- COPD (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome
- Peripheral Arterial Disease
- Low Back Pain
- Osteoarthritis
- Depression
- Anxiety
- Bipolar Disorder

To learn more or to enroll in the program, call 1.855.246.1873.

Once you complete the simple enrollment process, you will be provided with:

- Access to registered nurses who specialize in your condition.
- Information and resources that include assistance with self-care materials and services; and informative topic sheets on a variety of condition related topics.
- Reminders of self-care routines, exams and doctor appointments and other important topics.

**Cigna Health Care Healthy Babies® (Well Pregnancy Program)**

The Cigna Health Care Healthy Babies program provides education and support for covered mothers-to-be along with special attention for high-risk pregnancies. The program includes:

- Access to a valuable toll-free information line staffed by experienced registered nurses
- Educational materials from a recognized source of information on pregnancy and babies -- March of Dimes®.
- Post-delivery support and services. Once your baby arrives, Cigna Health Care continues to provide access to the services you'll need for the first few days and after.

Financial incentives (awarded after baby's birth) will be awarded to members who participate and meet the requirements of the program outlined at enrollment.

If you enroll…

- **Prenatal Vitamins:** Participants will receive their prescription prenatal vitamins free - no copays.
- **Preconception**: Up to 12 months before becoming pregnant - incentive equals **$225.**
- **Pregnancy** up to the **12th week** of pregnancy - incentive equals **$175.**
- From the **13th** to the **23rd week** of pregnancy - incentive equals **$50.**

For members enrolled in the Well Pregnancy Program, Child Birth classes are "free of charge" at specified locations.

Please call the OCPS Cigna On-Site Representative at 407.317.3200 Ext. 200 2487 or email CignaRepresentative@ocps.net.

**Hearing Aid Program**

This program allows coverage of hearing aids through the Cigna in-network provider, Amplifon/HearPo. This benefit will NOT be covered at an out-of-network provider. Your coverage includes:

- Up to two hearing aids in a covered three year period; maximum benefit of $3,000 per hearing aid device through the Cigna in-network provider, Amplifon/HearPo.
- Co-insurance and deductibles apply.

To access services, call Amplifon/HearPo at 1.888.207.2798.

**Smoking Cessation Program – Smoke Free OCPS**

This program is designed to assist individuals attempting to quit smoking. Components of the program include an eight week problem solving, social supportive educational class, ACA-covered smoking cessation prescription medications and over-the-counter (OTC) nicotine replacement and reimbursement for any group therapy costs. "Smoke-Free" participants pay for group therapy copayments; prescriptions are required for medications and OTC nicotine replacement. After 12 months of successfully quitting smoking, participants are eligible to receive reimbursements with proper documentation. Contact the Employee Wellness Program at 407.317.3200, Ext. 200 2929 to obtain an enrollment packet.

**The Cigna Health Care 24-Hour Health Information Line**

No matter where you are in the U.S., you can call the Cigna Health Care 24-Hour Health Information Line, toll-free at 1.800.CIGNA24 (1.800.244.6224).

- You can speak to a registered nurse for answers to your health questions, assistance in locating nearby medical facilities, and helpful self-care tips.
- You can listen to informative, recorded audio tapes on hundreds of health topics.
- This service is available around the clock, 24-hours a day, seven days a week.

**Cigna Telehealth offered through Cigna**

Easy and cost effective Cigna Telehealth solution that provides on-demand 24/7/365 access to non-urgent health care through a national network of licensed, board certified U.S. – based doctors and pediatricians. **Telehealth Services will be provided by both American Well (Amwell) and MDLIVE.**

You can talk with doctors by phone or video conference. Telehealth doctors can diagnose you, prescribe medications when appropriate and send the prescription directly to your pharmacy.

Covered expenses include: charges for the delivery of medical and health-related consultations via secure telecommunications technologies including telephones and internet, when delivered through a contracted medical telehealth provider.

**When to use it?** Cigna Telehealth is available 24 hours a day, seven days a week, 365 days a year to conveniently help you find treatment for minor, non-emergency conditions. You can use it anytime, from anywhere. All you need is a phone or computer with webcam. Use Cigna Telehealth to talk to a doctor about:

› Acne › Allergies › Asthma › Bronchitis › Cold & Flu › Diarrhea › Ear Aches › Fever › Head Ache › Infections › Insect Bites › Joint Aches › Nausea › Pink Eye › Rashes › Respiratory Infections › Sinus Infections › Skin Infections › Sore Throat › Urinary Tract Infections

**Child medical conditions** - Cold & Flu - Constipation - Ear Aches - Nausea - Pink Eye

For Copay plans – Pay $10 copay
For Deductible plans – Pay 100% of the cost of the visit until Deductible is met, then pay $10 copay

**To access Cigna Telehealth:**

Register online
Patient registers online with one or both vendors so they are ready to use service when needed

URL: www.MDLIVEforCigna.com
Toll free number: 888.726.3171

URL: www.AmwellforCigna.com
Toll free number: 855.667.9722

**By Phone:**
Step 1: Call toll-free
Patient calls toll-free hotline available 24/7/365 including holidays. MDLIVE 888.726.3171. American Well 855.667.9722
Step 2: Speak with a coordinator
A consultation coordinator locates the next available doctor and prepares patient for the consultation
Step 3: Speak with the doctor
Once an available doctor is located, the system automatically calls and connects the doctor to the patient vs. others.

**By Video Conference:**
Step 1: Visit website
Patient visits the American Well or MDLIVE website or can download each mobile app and log in with username and password.
Step 2: Find a doctor
System helps the patient search for a doctor by
a criteria, such as specialty, language, gender, location, or simply finds the next available doctor.
Step 3: See the doctor online
Once an available doctor is located, the system automatically connects the doctor to the patient.

**Post Visit:**
Email communication
Patient can elect for consultation history to be sent to personal doctor

**Prescription services**

Amwell and MDLIVE doctors may prescribe medication when appropriate and send the prescription directly to your pharmacy*.

Health care services are delivered by American Well and MDLIVE participating doctors and not by Cigna. Availability may vary by location and is subject to change. See vendor sites for details.
*American Well and MDLIVE do not guarantee that a prescription will be written. Not all prescriptions are available. The following services are generally not covered: services that aren't medically necessary; experimental, investigational or unproven services; services for an injury or illness that occurs while working for pay or profit, including services covered by Worker's Compensation benefits; treatment of sexual dysfunction. Amwell and MDLIVE are independent companies/entities and are not affiliated with Cigna. The services and websites are provided exclusively by Amwell and MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities. Video chat is not available in all areas. Amwell/MDLIVE services are separate from your health plan's provider network. Telehealth services may not be available to all plan types. A Primary Care Provider referral is not required for Amwell/MDLIVE services.

**Cigna Healthy Rewards Program**

Healthy Rewards is a discount program offered to Cigna members. Healthy Rewards offers discounts for acupuncture, laser vision correction, hearing aids, cosmetic dentistry, smoking cessation, fitness club memberships, herbal supplements and a variety of other services and programs. There are no claims to file. The discount applies the minute service is paid for. Members use their Cigna medical plan ID card for identification. Discounts apply only with Healthy Rewards participating providers. Members can find a list of providers and services by calling 1.800.870.3470 or by visiting www.cigna.com/healthyrewards or www.mycigna.com.

Healthy Rewards discounts can't be applied to any copayments or coinsurance for services already covered by your medical plan.

**Customer Service**

Cigna Customer Service:

- The toll-free number is 1.800.CIGNA24 (1.800.244.6224). Please have your Cigna Health Care ID card ready when you call.
- Cigna's Customer Service is available 24 hours a day, 7 days a week.
- Se habla Espanol - and more than 140 other languages. Cigna provides bi-lingual representatives in Spanish-speaking areas; for other non-English speaking members, Cigna also offers a Language Line service that can translate virtually any language.

**Cigna Health Care ID Card**

Carry it with you at all times and present it whenever you access medical care. This will help ensure that your claim is handled properly.

## EXCLUSIONS/LIMITATIONS

Expenses for the following are excluded and/or limited:

***MEDICAL PLAN***

1. Any treatment for cosmetic purposes or for cosmetic surgery, except that the plan will pay for cosmetic treatment or surgery:

    a. Due solely to an accidental bodily injury which occurred while the covered person was under this plan; or

    b. Due solely to a birth defect of a covered person's eligible dependent child.

2. Any service for the treatment of injury or illness considered not medically necessary and/or appropriate as determined by the medical director or his designee.

3. Collection or donation of blood products, except for autologous donation in anticipation of scheduled services where in the opinion of the Medical Director the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery. Blood administration for the purpose of general improvement of health.

4. Surgery to reverse surgical sterilization procedures.

5. Services and supplies related to sexual dysfunctions or inadequacies, or for sex change operations.

6. Fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or invitro fertilizations.

7. Care or services of any kind performed by or under the direct supervision of a dentist, except that the plan will pay for dental treatment necessary to repair injuries to sound, natural teeth caused by a non-occupational accident occurring while the covered person is covered and which are performed within six months of the accident. The contributing cause of the accident must be something other than teeth grinding, chewing, or biting.

8. Treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue of alveolar processes; however, benefits will be payable for the charges incurred for the treatment required because of accidental bodily injury to natural teeth sustained while covered (this exception shall not in any event be deemed to include expenses for treatment for the repair or replacement of a denture).

9. Non-surgical treatment involving bones and joints of the jaw and facial region. All orthognathic procedures and other craniomandibular disorder treatments not medically necessary.

10. Diagnosis or treatment of weak or flat feet, fallen or high arches, for instability or imbalance metatarsalgia not caused by disease (except for bone surgery), bunions (except for capsular or bone surgery), corns or calluses, or toenails (except for complete or partial removal of nail root); unless needed in treatment of a metabolic or peripheral vascular disease.

11. Routine hearing examinations, routine physical examinations, premarital examinations, pre-employment physicals, preschool examinations, or annual boosters except as indicated in the summary of benefits.

12. Hearing aids or examination for prescriptions or fitting of hearing aids, except as indicated in the summary of benefits.

13. Routine eye examination, eye glasses, contact lenses or their fitting (unless for initial replacement of the lens of the eye after cataract surgery), eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, any related examination and eye refraction, or radial keratatomy.

14. For experimental, investigational or unproven services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined to be:

    a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or

    b. The subject of review or approval by an Institutional Review Board for the proposed use; or

    c. The subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or

    d. Not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

15. Any organ or tissue transplant, except as otherwise listed in the Plan Document.

16. Education, training, and bed and board while confined to an institution which is primarily a school or other institution for training; a place of rest, a place for the aged, or for custodial care or for testing or training due to mental, nervous, or emotional conditions.

17. Education (excluding diabetes education), training, or counseling of any type no matter what the diagnosis. The mental health benefit covers counseling.

18. Health Services and associated expenses for bariatric procedures/surgeries intended primarily for the treatment of morbid obesity or weight loss, including but not limited to gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw and health services of a similar nature.

19. Weight control counseling or services primarily for weight loss or control. Necessary treatment for eating disorders, as defined by DSM-III-R codes, is covered under the mental health benefit approved by Orlando Behavioral Healthcare. Coverage for weight control is provided in network only and follows the guidelines set forth in the Health Care Reform Act at http://www.healthcare.gov/law/about/provisions/services/lists.html.

20. Vitamins, minerals, or food supplements, whether or not prescribed by a qualified practitioner.
    Exception: Legend vitamins and minerals when adequate nutrition cannot be sustained with over-the-counter vitamins and minerals. Clinically necessary I.V. hyperalimentation or when adequate nutrition cannot be sustained through usual pathway.

21. Any personal items while hospital confined.

22. Hospitalization primarily for x-ray, laboratory, diagnostic study, physical therapy, hydrotherapy, medical observation, convalescent or rest care, or any other medical examination or tests not clinically necessary.

23. Services, supplies, or tests not generally accepted in health care practices as needed in the diagnosis or treatment of the patient, even if ordered by a doctor.

24. Medical supplies such as adhesive tape, antiseptics, or other common first aid supplies.

25. Services provided by a person who usually lives in the same household as the covered person, or who is a member of his/her immediate family or the family of his/her spouse.

26. Those services incurred prior to the date coverage is in force or after coverage ends, except if the person is totally disabled on the date this medical plan ends.

27. Those services which a covered person would not be legally obligated to pay if health insurance coverage did not exist.

28. Illness for which the covered person is entitled to benefits under any worker's compensation law or act, or accidental bodily injury arising out of or in the course of the covered person's employment or services rendered by any governmental program (i.e., V.A. hospital) unless there is a legal obligation to pay for coverage.

29. Illness resulting from war, whether declared or undeclared.

30. Illness or injury to which a contribution cause was the commission of, or attempted commission of, an act of aggression or a felony, or participating in a riot by the covered person.

31. Any charges in excess of approved charges as determined by Cigna.

32. Claims not submitted within 12 months from the date of service.

33. All charges during a hospitalization deemed medically unnecessary or inappropriate by the medical director or his designee.

34. Penalties for failure to comply with any and all applicable precertification requirements.

35. Claims for services to improve a covered person's general physical condition, for private membership clubs and clinics, and for any other organization charging membership fees.

36. Any tests not requiring a physician's order and purchased over-the-counter.

37. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

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

# II. MEDICAL INSURANCE

**B. Plan B: Cigna Health Reimbursement Account (HRA)**

# II. MEDICAL INSURANCE
## Plan B: Cigna Health Reimbursement Account (HRA)

### OVERVIEW

Cigna Health Care Open Access Plus (HRA) is designed to provide the highest quality healthcare while maintaining your freedom to choose from a wide selection of personal physicians. You have the option to choose a Primary Care Physician (PCP) who specializes in one of these areas: family practice, internal medicine, general medicine or pediatrics. Your PCP or personal physician can be a source for routine care and for guidance if you need to see a specialist or require hospitalization. To access an online provider directory for these plans visit www.cigna.com, choose " Find a Doctor," choose "Open Access Plus, OA Plus, Choice Fund OA Plus." For detailed instructions in using the provider directory, please see page 11 of the *General Insurance Information* section of this handbook.

With these plans, you have the option to go to any medical person and facility. However, when choosing the providers in the Open Access Plus network, your benefit coverage will be a greater level than opting to receive services outside the Open Access Plus network. Also, with out of network health care professionals and facilities, you may be responsible for any amount over the maximum reimbursable charge.

Cigna Health Care Open Access Plus (HRA) provides well-managed services to deliver cost effective, quality care through the physicians' private offices and facilities. To ensure full and proper medical treatment, and reduce unnecessary procedures, this program emphasizes pre-admission screening, prior authorization for specific services, ambulatory services, home healthcare, and preventive care.

**Cigna Care Designation (CCD)** is designed to help promote quality care and to help employees and their families select the Health Care Professional (HCP) that's best for them. Utilizing Cigna claim information, HCPs are assigned the CCD designation when they meet Cigna's criteria for certain quality, and cost-efficiency measures. CCD is available in certain geographic locations.

This **Cigna Care Network (CCN) Plan** provides a higher level of In-Network benefits (coinsurance and/or copayment) when services are received from CCD HCPs in the following designated specialties:

| | | |
|---|---|---|
| **18 Specialist Types:** | Endocrinology | OB/GYN |
| Allergy/Immunology | Gastroenterology | Ophthalmology |
| Cardiology | General Surgery | Orthopedics/Surgery |
| Cardio-Thoracic Surgery | Hematology/Oncology | Pulmonology |
| Dermatology | Nephrology | Rheumatology |
| Ear/Nose/Throat | Neurology | Urology |
| | Neurosurgery | |

The In-Network benefits described in the companion summary show both CCN and Non-CCN copayment and coinsurance levels as applicable.
- Note that the CCN levels apply to professional charges and do not apply to facility charges.

**CCN level:**

- **CCN Designated** HCPs performing in one of the above specialties.

**Non-CCN level:**

- **Non-CCN Designated** HCPs performing any service.
- **Non-Reviewed Specialist** HCPs performing any service outside of the specialties identified above.

**CCN Tiering applies to Office visits and Inpatient and Outpatient Professional (Surgical) charges**, except for Radiologists, Pathologists and Anesthesiologists.

**Your employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the Plan Year.**

| | |
|---|---|
| **Employer Contribution** | Employee Only, Employee + Child(ren), Employee + Spouse or Employee + Full Family - One contribution of $250*<br><br>Half-Family – Each employee receives a contribution of $250.*<br><br>*The $250 contribution will be prorated if an employee elects coverage after the plan year begins. |

Please use the Summary of Benefits and Coverage as a guide to your plan. This schedule does not contain all provisions of your benefit plan.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For in-network providers: $2,000/individual or $4,000/family<br><br>For out-of-network providers: $3,000/individual or $6,000/family<br><br>Co-payments don't count toward the deductible. Deductible met July, August, September applies to current plan year and following plan year.<br><br>Amount your employer contributes to your account: Employee Only/Employee + Spouse/DP/Family - One contribution of $250;<br>Half-Family - Each Employee receives a contribution of $250 | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. In-network preventive care & immunizations, in-network office visits, mental health services, substance abuse services and prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services? | Yes, $100 deductible per type of scan per day for in-network & out-of-network imaging (CT/PET scans, MRIs) There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the out-of-pocket limit for this plan? | For in-network providers $4,500/individual or $9,000/family<br>For out-of-network providers $9,000/individual or $18,000/family<br><br>For in-network prescription drugs - $1,000 person/ $2,000 family<br>For in-network Mental Health/Substance Abuse - $500 person/ $1,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays ( balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider<br>(You will pay the least) | What You Will Pay<br>Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $30 copay/visit ** | 30% coinsurance | None |
| | Telehealth | $10 copay/visit ** | Not Covered | None |
| | Specialist visit | CCN Specialist:<br>$45 copay/visit **<br>Non-CCN Specialist: $65 copay/visit ** | 30% coinsurance | Contact your employer for Cigna Care Network specialties information |
| | Preventive care/ screening/ immunization | No charge/visit**<br>No charge/screening**<br>No charge/immunizations**<br><br>**Deductible does not apply | 30% coinsurance/visit<br>30% coinsurance/screening<br>30%coinsurance/ immunizations | None<br>None<br>None<br><br>You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | PCP: $30 copay/visit<br>CCN Specialist: $45 copay/visit<br>Non-CCN Specialist: $65 copay/visit<br>All Other: 20% coinsurance | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $100 copay per type of scan/day, plus 20% coinsurance | $100 deductible per type of scan/day, plus 30% coinsurance | $500 penalty for no precertification. CCN Benefit level may apply. |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider<br>(You will pay the least) | What You Will Pay<br>Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you need drugs to treat your illness or condition<br><br>More information about prescription drug coverage is available at www.caremark.com | Generic drugs<br>(Tier 1) | $7 co-pay: retail 30-day prescription<br>$14 co-pay: CVS/Caremark mail order or CVS Retail 90-day prescription<br>$21 co-pay: retail 90-day prescription | Co-insurance or co-payment plus the difference in cost between out-of-network and network cost to the plan | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| | Preferred brand drugs<br>(Tier 2) | $40 co-pay: retail 30-day prescription<br>$80 co-pay: CVS/Caremark mail order or CVS Retail 90-day prescription<br>$120 co-pay: retail 90-day | Co-insurance or co-payment plus the difference in cost between out-of-network and network cost to the plan | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| | Non-preferred brand drugs<br>(Tier 3) | Not covered | Not covered | See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| | Covered medications more than $1,500 for a 30 day supply | $75 co-pay: retail 30-day prescription<br>$150 co- pay: CVS/Caremark mail order or CVS Retail 90-day prescription<br>$225 co-pay: retail 90-day prescription | Co-insurance or co-payment plus the difference in cost between out-of-network and network cost to the plan | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | $500 penalty for no precertification. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | $500 penalty for no precertification. CCN Benefit level may apply for surgeon fees. |
| If you need immediate medical attention | Emergency room care | $300 copay/visit, plus 20% coinsurance | $300 copay/visit, plus 20% coinsurance | Per visit copay is waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | $75 copay/visit | $75 copay/visit | Per visit copay is waived if admitted. |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 30% coinsurance | $500 penalty for no precertification. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | $500 penalty for no precertification. CCN Benefit level may apply for surgeon fees. |
| If you have mental health, behavioral health, or substance abuse needs please contact: Orlando Behavioral Health at 407.637.8080 | The schedule of behavioral/mental health services is outlined in Section II. E. | | | |
| If you are pregnant | Office Visits | Primary Care Physician: $30<br>CCN Specialist: $45<br>Non-CCN Specialist: $65 | 30% coinsurance | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.<br>Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional charges | 20% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 30% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | <br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 30% coinsurance | $500 penalty for no precertification. Coverage is limited to 100 days annual max. Maximums cross-accumulate. 16 hour maximum per day |
| | Rehabilitation services | $25 copay | 30% coinsurance | $500 penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 50 days for Pulmonary Rehab, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic Care and Cardiac Rehab. |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | 20% coinsurance | 30% coinsurance | $500 penalty for no precertification. Coverage is limited to 120 days annual max. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | $500 penalty for no precertification. |
| | Hospice services | 20% coinsurance | 30% coinsurance | $500 penalty for no precertification. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Children)
- Eye care (Children)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids (in-network only/$3,000 maximum per 36 months)
- Private Duty Nursing

# About these Coverage Examples:

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

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

- The plan's overall deductible $2,000
- Specialist copayment $45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

| Total Example Cost | $12,800 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $200 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| The total Peg would pay is | $4,310 |

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

- The plan's overall deductible $2,000
- Specialist copayment $45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

| Total Example Cost | $7,400 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $130 |
| Copayments | $1,000 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| The total Joe would pay is | $1,430 |

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

- The plan's overall deductible $2,000
- Specialist copayment $45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

| Total Example Cost | $1,900 |
|---|---|

In this example, Mia would pay

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,080 |
| Copayments | $500 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,660 |

**Regarding In-Network Services:**

- All services must be provided by one of the preferred providers on the Cigna Open Access Plus Provider Directory.
- Once the plan year out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year.
- All inpatient hospital admissions require Pre-Certification and concurrent review will be performed during the hospital stay. Failure to obtain Pre-Certification and/or concurrent review may result in non-compliance penalties and/or reduction of benefits. Call the toll-free number on your Cigna Health Care ID Card.

**Regarding Out-of-Network Services:**

- Your out-of-pocket costs will be higher than with a preferred provider. Your out-of-network coverage pays a smaller share of the cost of your care than your in-network benefits. Some services may not be covered.
- You are responsible for the filing of claims. Save your claim information from the physician or facility along with the receipt of payment. For each claim filed, you will receive an Explanation of Benefits (EOB) that helps you keep track of your out-of-pocket payments, your deductible and the payments made by your plan.
- Services are covered only up to "reasonable and customary" amounts. These are determined by comparing what the physicians in the area charge for specific services. These are the maximum amounts your plan pays for out-of-network care. Any charges above these maximums are your responsibility. Services provided outside of the service area are only covered at 70% of what that same service would cost in the plan service area and are excluded from your out-of-pocket maximum. Any charges in excess will be the responsibility of the member in addition to the 30% co-insurance.
- Once the plan year out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year.
- All inpatient hospital admissions require Pre-Certification and concurrent review. Failure to obtain Pre-Certification and/or concurrent review may result in non-compliance penalties and/or reduction of benefits. Call the toll-free number on your Cigna Health Care ID Card.

**Cigna Open Access Plus Health Reimbursement Account (HRA)**
**PRECERTIFICATION/UTILIZATION MANAGEMENT**

The precertification/utilization management process ensures that you, as the patient, are receiving medical care and treatment that is appropriate, medically necessary and being performed in the best setting.

Therefore, if your physician recommends **hospitalization, outpatient surgery or defined procedures/services as listed below,** for you or your eligible dependent, **precertification** is required by **your physician for in-network services and by you and/or your physician for out of network services** by calling 1.800.CIGNA24 (1.800.244.6224) five (5) days prior to services being rendered. You **must** receive services from an in-network provider in order to receive your highest level of benefit reimbursement. You will receive a letter stating what services and/or treatments have been approved.

If your hospitalization is for a maternity stay, no authorization is required for a 48 hour stay for vaginal deliveries or a 96 hour stay for Cesarean section. Longer stay must be authorized by Cigna Health Care.

If admission is due to an emergency, you or a member of your family, and your physician must call Cigna Health Care at 1.800.CIGNA24 (1.800.244.6224) within 48 hours or as soon as possible. All emergency admissions will be reviewed for medical necessity.

Concurrent review will be performed during your hospital stay to ensure that continued hospitalization is warranted. You will be visited by a Cigna Health Care nurse to assist with any discharge needs you may have.

Precertification is required for **ALL** in-patient admissions, and the following list of services and procedures whether performed in a hospital, outpatient facility, or doctor's office:

- All elective and urgent/emergent admissions, observation stays, skilled nursing facility, rehab facilities, hospice facilities, and transfers between facilities.
- Any covered dental-treatments and procedures including, but not limited to: orthognathic procedures, TMJ procedures, procedures to treat injury to sound natural teeth.
- MRA, MRI, CT, and PET Scans
- Durable medical equipment
- Devices including, but not limited to: cochlear implants, insulin pumps
- Home health care and home infusion therapy
- Tonsillectomy – in-patient only
- Uvulopharyngopalatoplasty – in-patient only
- Hysterectomy
- Speech therapy, prior to the first visit

**Please note: List of services is subject to change without notice. When precertifying procedures, all claims are subject to retrospective review, if necessary, to confirm that procedures or services are covered and not excluded under the Plan Document.**

***PENALTIES***

**THE PRECERTIFICATION PROGRAM IS MANDATORY**. If services as listed are *not* precertified, up to a $500 penalty will be imposed on the covered person when utilizing an out-of-network physician.

**Serious Illness**

If you or a covered family member ever need care beyond a traditional hospital stay, Cigna Health Care Case Management service provides valuable counseling, support and care coordination. An experienced case manager, assigned specifically to your situation, works closely with your doctor to help you sort out your options, contact

facilities, arrange care, and access helpful community resources and programs.

For more information call Customer Service at the toll-free number on your Cigna Health Care ID card, 1.800.CIGNA24 (1.800.244.6224).

**The Cigna Health Care Your Health First Program**

Your Cigna Health Care plan includes the Cigna Health Care Your Health First Program for better health. It offers valuable, confidential support for you and your covered family members with specific medical conditions. The Cigna Health Care Your Health First Program provides educational materials that help you learn more about your health condition, regular reminders of important checkups and tests and helpful information that keeps your doctor advised of the latest care and treatment techniques.

The Cigna Health Care Your Health First Program helps you and your doctor follow your condition more closely and treat it more effectively.

The following programs are available:

- Asthma
- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- COPD (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome
- Peripheral Arterial Disease
- Low Back Pain
- Osteoarthritis
- Depression
- Anxiety
- Bipolar Disorder

To learn more or to enroll in the program, call 1.855.246.1873.

Once you complete the simple enrollment process, you will be provided with:

- Access to registered nurses who specialize in your condition.
- Information and resources that include assistance with self-care materials and services; and informative topic sheets on a variety of condition related topics.
- Reminders of self-care routines, exams and doctor appointments and other important topics.

**Cigna Health Care Healthy Babies® (Well Pregnancy Program)**

The Cigna Health Care Healthy Babies program provides education and support for covered mothers-to-be along with special attention for high-risk pregnancies. The program includes:

- Access to a valuable toll-free information line staffed by experienced registered nurses
- Educational materials from a recognized source of information on pregnancy and babies -- March of Dimes®.
- Post-delivery support and services. Once your baby arrives, Cigna Health Care continues to provide access to the services you'll need for the first few days and after.

Financial incentives (awarded after baby's birth) will be awarded to members who participate and meet the requirements of the program outlined at enrollment.

If you enroll…

- **Prenatal Vitamins:** Participants will receive their prescription prenatal vitamins free - no copays.
- **Preconception**: Up to 12 months before becoming pregnant - incentive equals **$225.**
- **Pregnancy** up to the **12th week** of pregnancy - incentive equals **$175.**
- From the **13th** to the **23rd week** of pregnancy - incentive equals **$50.**

For members enrolled in the Well Pregnancy Program, Child Birth classes are "free of charge" at specified locations.

Please call the OCPS Cigna On-Site Representative at 407.317.3200 Ext. 200 2487 or email CignaRepresentative@ocps.net.

**Hearing Aid Program**

This program allows coverage of hearing aids through the Cigna in-network provider, Amplifon/HearPo. This benefit will NOT be covered at an out-of-network provider. Your coverage includes:

- Up to two hearing aids in a covered three year period; maximum benefit of $3,000 per hearing aid device through the Cigna in-network provider, Amplifon/HearPo.
- Co-insurance and deductibles apply.

To access services, call Amplifon/HearPo at 1.888.207.2798.

**Smoking Cessation Program – Smoke Free OCPS**

This program is designed to assist individuals attempting to quit smoking. Components of the program include an eight week problem solving, social supportive educational class, ACA-covered smoking cessation prescription medications and over-the-counter (OTC) nicotine replacement and reimbursement for any prescription or over-the-counter (OTC) nicotine replacement and group therapy costs. "Smoke-Free" participants pay for group therapy copayments; prescriptions are required for medications and OTC nicotine replacement. After 12 months of successfully quitting smoking, participants are eligible to receive reimbursements with proper documentation. Contact the Employee Wellness Program at 407.317.3200, Ext. 2002929 to obtain an enrollment packet.

**The Cigna Health Care 24-Hour Health Information Line**

No matter where you are in the U.S., you can call the Cigna Health Care 24-Hour Health Information Line, toll-free at 1.800.CIGNA24 (1.800.244.6224).

- You can speak to a registered nurse for answers to your health questions, assistance in locating nearby medical facilities, and helpful self-care tips.
- You can listen to informative, recorded audio tapes on hundreds of health topics.
- This service is available around the clock, 24-hours a day, seven days a week.

**Cigna Telehealth offered through Cigna**

Easy and cost effective Cigna Telehealth solution that provides on-demand 24/7/365 access to non-urgent health care through a national network of licensed, board certified U.S. – based doctors and pediatricians. **Telehealth Services will be provided by both American Well (Amwell) and MDLIVE.**

You can talk with doctors by phone or video conference. Telehealth doctors can diagnose you, prescribe medications when appropriate and send the prescription directly to your pharmacy. Covered expenses include: charges for the

delivery of medical and health-related consultations via secure telecommunications technologies including telephones and internet, when delivered through a contracted medical telehealth provider.

**When to use it?** Cigna Telehealth is available 24 hours a day, seven days a week, 365 days a year to conveniently help you find treatment for minor, non-emergency conditions. You can use it anytime, from anywhere. All you need is a phone or computer with webcam. Use Cigna Telehealth to talk to a doctor about:

› Acne › Allergies › Asthma › Bronchitis › Cold & Flu › Diarrhea › Ear Aches › Fever › Head Ache › Infections › Insect Bites › Joint Aches › Nausea › Pink Eye › Rashes › Respiratory Infections › Sinus Infections › Skin Infections › Sore Throat › Urinary Tract Infections

**Child medical conditions** - Cold & Flu - Constipation - Ear Aches - Nausea - Pink Eye

For Copay plans – Pay $10 copay
For Deductible plans – Pay 100% of the cost of the visit until deductible is met, then pay $10 copay

**To access Cigna Telehealth:**

Register online
Patient registers online with one or both vendors so they are ready to use service when needed

URL: www.MDLIVEforCigna.com
Toll free number: 888.726.3171

URL: www.AmwellforCigna.com
Toll free number: 855.667.9722

**By Phone:**
Step 1: Call toll-free
Patient calls toll-free hotline available 24/7/365 including holidays. MDLIVE 888.726.3171. American Well 855.667.9722
Step 2: Speak with a coordinator
A consultation coordinator locates the next available doctor and prepares patient for the consultation
Step 3: Speak with the doctor
Once an available doctor is located, the system automatically calls and connects the doctor to the patient vs. others.

**By Video Conference:**
Step 1: Visit website
Patient visits the American Well or MDLIVE website or can download each mobile app and log in with username and password.
Step 2: Find a doctor
System helps the patient search for a doctor by
a criteria, such as specialty, language, gender, location, or simply finds the next available doctor.
Step 3: See the doctor online
Once an available doctor is located, the system automatically connects the doctor to the patient.

**Post Visit:**
Email communication
Patient can elect for consultation history to be sent to personal doctor

**Prescription services**
Amwell and MDLIVE doctors may prescribe medication when appropriate and send the prescription directly to your pharmacy*.

Health care services are delivered by American Well and MDLIVE participating doctors and not by Cigna. Availability may vary by location and is subject to change. See vendor sites for details.
*American Well and MDLIVE do not guarantee that a prescription will be written. Not all prescriptions are available. The following services are generally not covered: services that aren't medically necessary; experimental, investigational or unproven services; services for an injury or illness that occurs while working for pay or profit, including services covered by Worker's Compensation benefits; treatment of sexual dysfunction. Amwell and MDLIVE are independent companies/entities and are not affiliated with Cigna. The services and websites are provided exclusively by Amwell and MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities. Video chat is not available in all areas. Amwell/MDLIVE services are separate from your health plan's provider network. Telehealth services may not be available to all plan types. A Primary Care Provider referral is not required for Amwell/MDLIVE services.

**Cigna Healthy Rewards Program**

Healthy Rewards is a discount program offered to Cigna members. Healthy Rewards offers discounts for acupuncture, laser vision correction, hearing aids, cosmetic dentistry, smoking cessation, fitness club memberships, herbal supplements and a variety of other services and programs. There are no claims to file. The discount applies the minute service is paid for. Members use their Cigna medical plan ID card for identification. Discounts apply only with Healthy Rewards participating providers. Members can find a list of providers and services by calling 1.800.870.3470 or by visiting www.cigna.com/healthyrewards or www.mycigna.com.

Healthy Rewards discounts can't be applied to any copayments or coinsurance for services already covered by your medical plan.

**Customer Service**

Cigna Customer Service:

- The toll-free number is 1.800.CIGNA24 (1.800.244.6224). Please have your Cigna Health Care ID card ready when you call.
- Cigna's Customer Service is available 24 hours a day, 7 days a week.
- Se habla Espanol - and more than 140 other languages. Cigna provides bi-lingual representatives in Spanish-speaking areas; for other non-English speaking members, Cigna also offers a Language Line service that can translate virtually any language.

**Cigna Health Care ID Card**

Carry it with you at all times and present it whenever you access medical care. This will help ensure that your claim is handled properly.

## EXCLUSIONS/LIMITATIONS

Expenses for the following are excluded and/or limited:

***MEDICAL PLAN***

1. Any treatment for cosmetic purposes or for cosmetic surgery, except that the plan will pay for cosmetic treatment or surgery:

   a. Due solely to an accidental bodily injury which occurred while the covered person was under this plan; or

   b. Due solely to a birth defect of a covered person's eligible dependent child.

2. Any service for the treatment of injury or illness considered not medically necessary and/or appropriate as determined by the medical director or his designee.

3. Collection or donation of blood products, except for autologous donation in anticipation of scheduled services where in the opinion of the Medical Director the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery. Blood administration for the purpose of general improvement of health.

4. Surgery to reverse surgical sterilization procedures.

5. Services and supplies related to sexual dysfunctions or inadequacies, or for sex change operations.

6. Fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or invitro fertilizations.

7. Care or services of any kind performed by or under the direct supervision of a dentist, except that the plan will pay for dental treatment necessary to repair injuries to sound, natural teeth caused by a non- occupational accident occurring while the covered person is covered and which are performed within six months of the accident. The contributing cause of the accident must be something other than teeth grinding, chewing, or biting.

8. Treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue of alveolar processes; however, benefits will be payable for the charges incurred for the treatment required because of accidental bodily injury to natural teeth sustained while covered (this exception shall not in any event be deemed to include expenses for treatment for the repair or replacement of a denture).

9. Non-surgical treatment involving bones and joints of the jaw and facial region. All orthognathic procedures and other craniomandibular disorder treatments not medically necessary.

10. Diagnosis or treatment of weak or flat feet, fallen or high arches, for instability or imbalance metatarsalgia not caused by disease (except for bone surgery), bunions (except for capsular or bone surgery), corns or calluses, or toenails (except for complete or partial removal of nail root); unless needed in treatment of a metabolic or peripheral vascular disease.

11. Routine hearing examinations, routine physical examinations, premarital examinations, pre-employment physicals, preschool examinations, or annual boosters except as indicated in the summary of benefits.

12. Hearing aids or examination for prescriptions or fitting of hearing aids, except as indicated in the summary of benefits.

13. Routine eye examination, eye glasses, contact lenses or their fitting (unless for initial replacement of the lens of the eye after cataract surgery), eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, any related examination and eye refraction, or radial keratatomy.

14. For experimental, investigational or unproven services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined to be:

    a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or

    b. The subject of review or approval by an Institutional Review Board for the proposed use; or

    c. The subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or

    d. Not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

15. Any organ or tissue transplant, except as otherwise listed in the Plan Document.

16. Education, training, and bed and board while confined to an institution which is primarily a school or other institution for training; a place of rest, a place for the aged, or for custodial care or for testing or training due to mental, nervous, or emotional conditions.

17. Education (excluding diabetes education), training, or counseling of any type no matter what the diagnosis. The mental health benefit covers counseling.

18. Health Services and associated expenses for bariatric procedures/surgeries intended primarily for the treatment of morbid obesity or weight loss, including but not limited to gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw and health services of a similar nature.

19. Weight control counseling or services primarily for weight loss or control. Necessary treatment for eating disorders, as defined by DSM-III-R codes, is covered under the mental health benefit approved by Orlando Behavioral Healthcare. Coverage for weight control is provided in network only and follows the guidelines set forth in the Health Care Reform Act at http://www.healthcare.gov/law/about/provisions/services/lists.html.

20. Vitamins, minerals, or food supplements, whether or not prescribed by a qualified practitioner.

    Exception: Legend vitamins and minerals when adequate nutrition cannot be sustained with over-the-counter vitamins and minerals. Clinically necessary I.V. hyperalimentation or when adequate nutrition cannot be sustained through usual pathway.

21. Any personal items while hospital confined.

22. Hospitalization primarily for x-ray, laboratory, diagnostic study, physical therapy, hydrotherapy, medical observation, convalescent or rest care, or any other medical examination or tests not clinically necessary.

23. Services, supplies, or tests not generally accepted in health care practices as needed in the diagnosis or treatment of the patient, even if ordered by a doctor.

24. Medical supplies such as adhesive tape, antiseptics, or other common first aid supplies.

25. Services provided by a person who usually lives in the same household as the covered person, or who is a member of his/her immediate family or the family of his/her spouse.

26. Those services incurred prior to the date coverage is in force or after coverage ends, except if the person is totally disabled on the date this medical plan ends.

27. Those services which a covered person would not be legally obligated to pay if health insurance coverage did not exist.

28. Illness for which the covered person is entitled to benefits under any worker's compensation law or act, or accidental bodily injury arising out of or in the course of the covered person's employment or services rendered by any governmental program (i.e., V.A. hospital) unless there is a legal obligation to pay for coverage.

29. Illness resulting from war, whether declared or undeclared.

30. Illness or injury to which a contribution cause was the commission of, or attempted commission of, an act of aggression or a felony, or participating in a riot by the covered person.

31. Any charges in excess of approved charges as determined by Cigna.

32. Claims not submitted within 12 months from the date of service.

33. All charges during a hospitalization deemed medically unnecessary or inappropriate by the medical director or his designee.

34. Penalties for failure to comply with any and all applicable precertification requirements.

35. Claims for services to improve a covered person's general physical condition, for private membership clubs and clinics, and for any other organization charging membership fees.

36. Any tests not requiring a physician's order and purchased over-the-counter.

37. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

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

# II. MEDICAL INSURANCE

**C. Plan C: Cigna OAP In-Network**

# II. MEDICAL INSURANCE
## C. Plan C: Cigna OAP In-Network

### OVERVIEW

The Cigna Health Care OAP In-Network plan is designed to provide high quality healthcare to you and your family. You have the option to choose a "Primary Care Physician" (PCP) who specializes in one of four areas: family practice, internal medicine, general medicine or pediatrics. Your PCP or personal physician can be a source for routine care and for guidance if you need to see a specialist or require hospitalization.

With the Cigna Health Care OAP In-Network plan no referrals are needed to see a participating specialist. If you see a provider who is not in the Cigna Open Access Plus network, your plan does not cover those services, except in emergencies. Each family member can choose his or her own PCP.

To access an online provider directory for the Cigna OAP In-Network plan visit www.cigna.com, choose "Find A Doctor," choose "Open Access Plus, OA Plus, Choice Fund OA Plus." For detailed instructions in using the provider directory, please see page 11 of the *General Insurance Information* section of this handbook.

Cigna Health Care Network provides cost-effective, high quality healthcare services through participating physician offices and facilities. To ensure full and proper medical treatment, this program emphasizes pre-admission screening, prior authorization for specific services, ambulatory services, home healthcare, and preventive care.

Please use the Summary of Benefits and Coverage as a guide to your plan. This schedule does not contain all provisions of your benefit plan.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For in-network providers: $100/individual or $200/family<br><br>Co-payments don't count toward the deductible. Deductible amounts met in July, August, September will apply to the current plan year and following plan year. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. In-network preventive care & immunizations, office visits, emergency room visits, urgent care facility visits, mental health services, substance abuse services and prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | For in-network providers $4,500/individual or $9,000/family<br><br>For in-network prescription drugs - $1,000 person/ $2,000 family<br>For in-network Mental Health/Substance Abuse - $500 person/ $1,000 family | The out-of-pocket limit is the most you could pay in a year for covered services.If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| Will you pay less if you use a network provider? | Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $25 copay/visit<br>Deductible does not apply | Not covered | None |
| | Telehealth | $10/visit | Not covered | None |
| | Specialist visit | $45 copay/visit<br>Deductible does not apply | Not covered | None |
| | Preventive care/ screening/ immunization | No charge/visit**<br>No charge/screening**<br>No charge/immunizations**<br><br>**Deductible does not apply | Not covered | None<br><br>You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | Plan pays 100%** (physician's office/independent lab)<br>20% coinsurance (inpatient or outpatient services) | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $100 copay per type of scan/day, then plan pays 100% | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you need drugs to treat your illness or condition<br><br>More information about prescription drug coverage is available at www.caremark.com | Generic drugs (Tier 1) | $7 co-pay: retail 30-day prescription<br>$14 co-pay: CVS/Caremark mail order or CVS Retail 90- day prescription<br>$21 co-pay: retail 90-day prescription | Not Covered | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| | Preferred brand drugs (Tier 2) | $40 co-pay: retail 30-day prescription<br>$80 co-pay: CVS/Caremark mail order or CVS Retail 90- day prescription<br>$120 co-pay: retail 90-day prescription | Not Covered | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| | Non-preferred brand drugs (Tier 3) | Not covered | Not covered | See Insurance Benefits Handbook for full list of Exclusions/Limitations |
| | Covered Medications more than $1,500 for a 30 day supply. | $75 co-pay: retail 30-day prescription<br>$150 co-pay: CVS/Caremark mail order or CVS Retail 90- day prescription<br>$225 co-pay: retail 90-day prescription | Not Covered | Maintenance drugs are not covered at retail beginning with the 4th fill of a 30-day supply. See Insurance Benefits Handbook for full list of Exclusions/Limitations. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| If you need immediate medical attention | Emergency room care | $300 copay/visit Deductible does not apply | $300 copay/visit | Per visit copay is waived if admitted |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | $35 copay/visit Deductible does not apply | $35 copay/visit | Per visit copay is waived if admitted |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider<br>(You will pay the least) | <br>Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you have mental health, behavioral health, or substance abuse needs please contact: Orlando Behavioral Healthcare at 407.637.8080 | The schedule of benefits for behavioral/mental health is outlined in Section II. E. | | | |
| If you are pregnant | Office visits | $25 PCP or $45 Specialist copay,<br>Deductible does not apply | Not covered | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.<br>Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | $150 copay, plus 20% coinsurance,<br>Deductible does not apply. | Not covered | |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider<br>(You will pay the least) | <br>Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If you need help recovering or have other special health needs | Home health care | Plan pays 100%** | Not covered | Coverage is limited to 100 days in-network annual max. 16 hour maximum per day |
| | Rehabilitation services | $25 copay/visit<br>Deductible does not apply | Not covered | Coverage is limited to annual max of: 50 days for Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy Chiropractic care services and Cardiac rehab services. |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | 20% coinsurance | Not covered | Coverage is limited to 120 days annual max. |
| | Durable medical equipment | Plan pays 100% | Not covered | None |
| | Hospice services | Inpatient Services 20% coinsurance<br><br>Outpatient Services plan pays 100% | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Children)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Eye Care (Adult & Children)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids ($3,000 maximum per 36 months)
- Private Duty Nursing

# About these Coverage Examples:

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

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

- The plan's overall deductible $100
- Specialist copayment $45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

| Total Example Cost | $12,800 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $190 |
| Coinsurance | $2,500 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| The total Peg would pay is | $2,800 |

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

- The plan's overall deductible $100
- Specialist copayment $45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

| Total Example Cost | $7,400 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $900 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| The total Joe would pay is | $1,300 |

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

- The plan's overall deductible $100
- Specialist copayment $45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

| Total Example Cost | $1,900 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $400 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $800 |

## Cigna NETWORK
## PRECERTIFICATION/UTILIZATION MANAGEMENT

The precertification/utilization management process ensures that you, as the patient, are receiving medical care and treatment that is appropriate, medically necessary and being performed in the best setting.

Therefore, if your physician recommends **hospitalization, out-patient surgery or defined procedures/services as listed below,** for you or your eligible dependent, **precertification** is required by **your physician for in-network services and by your physician for out of network services by calling** 1.800.CIGNA24 (1.800.244.6224) five (5) days prior to services being rendered. You **must** receive services from an in-network provider in order to receive your highest level of benefit reimbursement. You will receive a letter stating what services and/or treatments have been approved.

If your hospitalization is for a maternity stay, no authorization is required for a 48 hour stay for vaginal deliveries or a 96 hour stay for Cesarean section. Longer stay must be authorized by Cigna Health Care.

If admission is due to an emergency, you or a member of your family, and your physician must call Cigna Health Care at 1.800.244.6224 (1.800.CIGNA24) within 48 hours/next working day following the admission. All emergency admissions will be reviewed for medical necessity.

Concurrent review will be performed during your hospital stay to ensure that continued hospitalization is warranted. You will be visited by a Cigna Health Care nurse to assist with any discharge needs you may have.

Precertification is required for **ALL** in-patient admissions, and the following list of services and procedures whether performed in a hospital, outpatient facility, or doctor's office:

- All elective and urgent/emergent admissions, observation stays, skilled nursing facility, rehab facilities, hospice facilities, and transfers between facilities.
- Any covered dental-treatments and procedures including, but not limited to: orthognathic procedures, TMJ procedures, procedures to treat injury to sound natural teeth.
- MRA, MRI, CT, and PET Scans
- Durable medical equipment
- Devices including, but not limited to: cochlear implants, insulin pumps
- Home health care and home infusion therapy
- Tonsillectomy – in-patient only
- Uvulopharyngopalatoplasty – in-patient only
- Hysterectomy
- Speech therapy, prior to the first visit

**Please note: List of services is subject to change without notice. When precertifying procedures, all claims are subject to retrospective review, if necessary, to confirm that procedures or services are covered and not excluded under the Plan Document.**

**Serious Illness**

If you or a covered family member ever need care beyond a traditional hospital stay, Cigna Health Care Case Management service provides valuable counseling, support and care coordination. An experienced case manager, assigned specifically to your situation, works closely with your doctor to help you sort out your options, contact facilities, arrange care, and access helpful community resources and programs.

For more information call Customer Service at the toll-free number on your Cigna Health Care ID card, 1.800.CIGNA24 (1.800.244.6224).

**The Cigna Health Care Your Health First Program**

Your Cigna Health Care plan includes the Cigna Health Care Your Health First Program for better health. It offers valuable, confidential support for you and your covered family members with specific medical conditions. The Cigna Health Care Your Health First Program provides educational materials that help you learn more about your health condition, regular reminders of important checkups and tests and helpful information that keeps your doctor advised of the latest care and treatment techniques.

The Cigna Health Care Your Health First Program helps you and your doctor follow your condition more closely and treat it more effectively.

The following programs are available:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- COPD (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Asthma
- Metabolic Syndrome
- Peripheral Arterial Disease
- Low Back Pain
- Osteoarthritis
- Depression
- Anxiety
- Bipolar Disorder

To learn more or to enroll in the program, call 1.855.246.1873.

Once you complete the simple enrollment process, you will be provided with:

- Access to registered nurses who specialize in your condition.
- Information and resources that include assistance with self-care materials and services; and informative topic sheets on a variety of condition related topics.
- Reminders of self-care routines, exams and doctor appointments and other important topics.

**Cigna Health Care Healthy Babies® (Well Pregnancy Program)**

The Cigna Health Care Healthy Babies program provides education and support for covered mothers-to-be along with special attention for high-risk pregnancies. The program includes:

- Access to a valuable toll-free information line staffed by experienced registered nurses
- Educational materials from a recognized source of information on pregnancy and babies -- March of Dimes®.
- Post-delivery support and services. Once your baby arrives, Cigna Health Care continues to provide access to the services you'll need for the first few days and after.

Financial incentives (awarded after baby's birth) will be awarded to members who participate and meet the requirements of the program outlined at enrollment.

If you enroll…

- **Prenatal Vitamins:** Participants will receive their prescription prenatal vitamins free - no copays.
- **Preconception**: Up to 12 months before becoming pregnant – incentive equals **$225.**
- **Pregnancy** up to the **12th week** of pregnancy- - incentive equals **$175.**
- From the **13th** to the **23rd week** of pregnancy - - incentive equals **$50.**

For members enrolled in the Well Pregnancy Program, Child Birth classes are "free of charge" at specified locations.

Please call the OCPS Cigna On-Site Representative at 407.317.3200 Ext. 200 2487 or email CignaRepresentative@ocps.net.

**Hearing Aid Program**

This program allows coverage of hearing aids through the Cigna in-network provider, Amplifon/HearPo. This benefit will NOT be covered at an out-of-network provider. Your coverage includes:

- Up to two hearing aids in a covered three year period; maximum benefit of $3,000 per hearing aid device through the Cigna in-network provider, Amplifon/HearPo.
- Co-insurance and deductibles apply.

To access services, call Amplifon/HearPo at 1.888.207.2798.

**Smoking Cessation Program – Smoke Free OCPS**

This program is designed to assist individuals attempting to quit smoking. Components of the program include an eight week problem solving, social supportive educational class, ACA-covered smoking cessation prescription medications and over-the-counter (OTC) nicotine replacement and reimbursement for any group therapy costs. "Smoke-Free" participants pay for group therapy copayments; prescriptions are required for medications and OTC nicotine replacement. After 12 months of successfully quitting smoking, participants are eligible to receive reimbursements with proper documentation. Contact the Employee Wellness Program at 407.317.3200, Ext. 200 2929 to obtain an enrollment packet.

**The Cigna Health Care 24-Hour Health Information Line**

No matter where you are in the U.S., you can call the Cigna Health Care 24-Hour Health Information Line, toll-free at 1.800.CIGNA24 (1.800.244.6224).

- You can speak to a registered nurse for answers to your health questions, assistance in locating nearby medical facilities, and helpful self-care tips.
- You can listen to informative, recorded audio tapes on hundreds of health topics.
- This service is available around the clock, 24-hours a day, seven days a week.

**Cigna Telehealth offered through Cigna**

Easy and cost effective Cigna Telehealth solution that provides on-demand 24/7/365 access to non-urgent health care through a national network of licensed, board certified U.S. – based doctors and pediatricians. **Telehealth Services will be provided by both American Well (Amwell) and MDLIVE.**

You can talk with doctors by phone or video conference. Telehealth doctors can diagnose you, prescribe medications when appropriate and send the prescription directly to your pharmacy. Covered expenses include: charges for the delivery of medical and health-related consultations via secure telecommunications technologies including telephones and internet, when delivered through a contracted medical telehealth provider.

**When to use it?** Cigna Telehealth is available 24 hours a day, seven days a week, 365 days a year to conveniently help you find treatment for minor, non-emergency conditions. You can use it anytime, from anywhere. All you need is a phone or computer with webcam. Use Cigna Telehealth to talk to a doctor about:

› Acne › Allergies › Asthma › Bronchitis › Cold & Flu › Diarrhea › Ear Aches › Fever › Head Ache › Infections › Insect Bites › Joint Aches › Nausea › Pink Eye › Rashes › Respiratory Infections › Sinus Infections › Skin Infections › Sore Throat › Urinary Tract Infections

**Child medical conditions** - Cold & Flu - Constipation - Ear Aches - Nausea - Pink Eye

For Copay plans – Pay $10 copay

For Deductible plans – Pay 100% of the cost of the visit until Deductible is met, then pay $10 copay

**To access Cigna Telehealth:**

Register online
Patient registers online with one or both vendors so they are ready to use service when needed

URL: MDLIVEforCigna.com
Toll free number: 888.726.3171

URL: AmwellforCigna.com
Toll free number: 855.667.9722

**By Phone:**
Step 1: Call toll-free
Patient calls toll-free hotline available 24/7/365 including holidays. MDLIVE 888.726.3171. American Well 855.667.9722
Step 2: Speak with a coordinator
A consultation coordinator locates the next available doctor and prepares patient for the consultation
Step 3: Speak with the doctor
Once an available doctor is located, the system automatically calls and connects the doctor to the patient vs. others.

**By Video Conference:**
Step 1: Visit website
Patient visits the American Well or MDLIVE website or can download each mobile app and log in with username and password.
Step 2: Find a doctor
System helps the patient search for a doctor by
a criteria, such as specialty, language, gender, location, or simply finds the next available doctor.
Step 3: See the doctor online
Once an available doctor is located, the system automatically connects the doctor to the patient.

**Post Visit:**
Email communication
Patient can elect for consultation history to be sent to personal doctor

**Prescription services**
Amwell and MDLIVE doctors may prescribe medication when appropriate and send the prescription directly to your pharmacy*.

Health care services are delivered by American Well and MDLIVE participating doctors and not by Cigna. Availability may vary by location and is subject to change. See vendor sites for details.
*American Well and MDLIVE do not guarantee that a prescription will be written. Not all prescriptions are available. The following services are generally not covered: services that aren't medically necessary; experimental, investigational or unproven services; services for an injury or illness that occurs while working for pay or profit, including services covered by Worker's Compensation benefits; treatment of sexual dysfunction. Amwell and MDLIVE are independent companies/entities and are not affiliated with Cigna. The services and websites are provided exclusively by Amwell and MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities. Video chat is not available in all areas. Amwell/MDLIVE services are separate from your health plan's provider network. Telehealth services may not be available to all plan types. A Primary Care Provider referral is not required for Amwell/MDLIVE services.

**Cigna Healthy Rewards Program**

Healthy Rewards is a discount program offered to Cigna members. Healthy Rewards offers discounts for acupuncture, laser vision correction, hearing aids, cosmetic dentistry, smoking cessation, fitness club memberships, herbal supplements and a variety of other services and programs. There are no claims to file. The discount applies

the minute service is paid for. Members use their Cigna medical plan ID card for identification. Discounts apply only with Healthy Rewards participating providers. Members can find a list of providers and services by calling 1.800.870.3470 or by visiting www.cigna.com/healthyrewards or www.mycigna.com.

Healthy Rewards discounts can't be applied to any copayments or coinsurance for services already covered by your medical plan.

**Customer Service**

Cigna Customer Service:

- The toll-free number is 1.800.CIGNA24 (1.800.244.6224). Please have your Cigna Health Care ID card ready when you call.
- Cigna's Customer Service is available 24 hours a day, 7 days a week.
- Se habla Espanol - and more than 140 other languages. Cigna provides bi-lingual representatives in Spanish-speaking areas; for other non-English speaking members, Cigna also offers a Language Line service that can translate virtually any language.

**Cigna Health Care ID Card**

Carry it with you at all times and present it whenever you access medical care. This will help ensure that your claim is handled properly.

## EXCLUSIONS/LIMITATIONS

Expenses for the following are excluded and/or limited:

***MEDICAL PLAN***

1. Any treatment for cosmetic purposes or for cosmetic surgery, except that the plan will pay for cosmetic treatment or surgery:

    a. Due solely to an accidental bodily injury which occurred while the covered person was under this plan; or

    b. Due solely to a birth defect of a covered person's eligible dependent child.

2. Any service for the treatment of injury or illness considered not medically necessary and/or appropriate as determined by the medical director or his designee.

3. Collection or donation of blood products, except for autologous donation in anticipation of scheduled services where in the opinion of the Medical Director the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery. Blood administration for the purpose of general improvement of health.

4. Surgery to reverse surgical sterilization procedures.

5. Services and supplies related to sexual dysfunctions or inadequacies, or for sex change operations.

6. Fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or invitro fertilizations.

7. Care or services of any kind performed by or under the direct supervision of a dentist, except that the plan will pay for dental treatment necessary to repair injuries to sound, natural teeth caused by a non-occupational accident occurring while the covered person is covered and which are performed within six months of the accident. The contributing cause of the accident must be something other than teeth grinding, chewing, or biting.

8. Treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue of alveolar processes; however, benefits will be payable for the charges incurred for the treatment required because of accidental bodily injury to natural teeth sustained while covered (this exception shall not in any event be deemed to include expenses for treatment for the repair or replacement of a denture).

9. Non-surgical treatment involving bones and joints of the jaw and facial region. All orthognathic procedures and other craniomandibular disorder treatments not medically necessary.

10. Diagnosis or treatment of weak or flat feet, fallen or high arches, for instability or imbalance metatarsalgia not caused by disease (except for bone surgery), bunions (except for capsular or bone surgery), corns or calluses, or toenails (except for complete or partial removal of nail root); unless needed in treatment of a metabolic or peripheral vascular disease.

11. Routine hearing examinations, routine physical examinations, premarital examinations, pre-employment physicals, preschool examinations, or annual boosters except as indicated in the summary of benefits.

12. Hearing aids or examination for prescriptions or fitting of hearing aids, except as indicated in the summary of benefits.

13. Routine eye examination, eye glasses, contact lenses or their fitting (unless for initial replacement of the lens of the eye after cataract surgery), eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, any related examination and eye refraction, or radial keratotomy.

14. For experimental, investigational or unproven services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined to be:

a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or

b. The subject of review or approval by an Institutional Review Board for the proposed use; or

c. The subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or

d. Not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

15. Any organ or tissue transplant, except as otherwise listed in the Plan Document.

16. Education, training, and bed and board while confined to an institution which is primarily a school or other institution for training; a place of rest, a place for the aged, or for custodial care or for testing or training due to mental, nervous, or emotional conditions.

17. Education (excluding diabetes education), training, or counseling of any type no matter what the diagnosis. The mental health benefit covers counseling.

18. Health Services and associated expenses for bariatric procedures/surgeries intended primarily for the treatment of morbid obesity or weight loss, including but not limited to gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw and health services of a similar nature.

19. Weight control counseling or services primarily for weight loss or control. Necessary treatment for eating disorders as defined by DSM-III-R codes, is covered under the mental health benefit approved by Orlando Behavioral Healthcare. Coverage for weight control is provided and follows the guidelines set forth in the Health Care Reform Act at http://www.healthcare.gov/law/about/provisions/services/lists.html.

20. Vitamins, minerals, or food supplements, whether or not prescribed by a qualified practitioner.
    Exception: Legend vitamins and minerals when adequate nutrition cannot be sustained with over-the-counter vitamins and minerals. Clinically necessary I.V. hyperalimentation or when adequate nutrition cannot be sustained through usual pathway.

21. Any personal items while hospital confined.

22. Hospitalization primarily for x-ray, laboratory, diagnostic study, physical therapy, hydrotherapy, medical observation, convalescent or rest care, or any other medical examination or tests not clinically necessary.

23. Services, supplies, or tests not generally accepted in health care practices as needed in the diagnosis or treatment of the patient, even if ordered by a doctor.

24. Medical supplies such as adhesive tape, antiseptics, or other common first aid supplies.

25. Services provided by a person who usually lives in the same household as the covered person, or who is a member of his/her immediate family or the family of his/her spouse.

26. Those services incurred prior to the date coverage is in force or after coverage ends, except if the person is totally disabled on the date this medical plan ends.

27. Those services which a covered person would not be legally obligated to pay if health insurance coverage did not exist.

28. Illness for which the covered person is entitled to benefits under any worker's compensation law or act, or accidental bodily injury arising out of or in the course of the covered person's employment or services rendered by any governmental program (i.e., V.A. hospital) unless there is a legal obligation to pay for coverage.

29. Illness resulting from war, whether declared or undeclared.

30. Illness or injury to which a contribution cause was the commission of, or attempted commission of, an act of aggression or a felony, or participating in a riot by the covered person.

31. Any charges in excess of approved charges as determined by Cigna.

32. Claims not submitted within 12 months from the date of service.

33. All charges during a hospitalization deemed medically unnecessary or inappropriate by the medical director or his designee.

34. Penalties for failure to comply with any and all applicable precertification requirements.

35. Claims for services to improve a covered person's general physical condition, for private membership clubs and clinics, and for any other organization charging membership fees.

36. Any tests not requiring a physician's order and purchased over-the-counter.

37. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

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

# II. MEDICAL INSURANCE

**D. CVS/Caremark**

**(Your Pharmacy Benefits for ALL Medical Plans)**

# CVS/Caremark Pharmacy Benefits

**Your Pharmacy Plan**
CVS/Caremark provides benefits for covered drugs, which are prescribed by your physician and obtained from a participating pharmacy.

**Purchasing Non-Maintenance Medications**
If your prescription for a non-maintenance drug is for up to 30-days you may visit any participating retail pharmacy. Unlike maintenance medications there is no limit to the number of times you may fill your prescription at the retail pharmacy.

**Purchasing Maintenance Medications**
If you or a covered family member receives a prescription for a maintenance medication (any long-term medications you are taking for 90 days or more such as cholesterol, blood pressure, diabetes, as well as oral contraceptives), you can obtain the first 30-day fill and up to two 30-day refills at any participating retail pharmacy. Thereafter, you must purchase your maintenance medication through either the CVS/ Caremark pharmacy or the 90-day retail program at participating retail pharmacies. **Otherwise each subsequent fill of a 30-day supply will be 100% of the CVS/Caremark discounted cost of the medication.**

**CVS/Caremark Mail Service or CVS Retail Stores (Maintenance Drugs)**
CVS/Caremark Mail Service or CVS Retail Stores (including Target Pharmacies) provide a 90-day supply for twice the monthly copayment.

**Retail 90 (Maintenance Drugs)**
Copayments at Retail 90 are three times the 30-day copayment. To use Retail 90 simply bring your 90-day prescription for a maintenance medication to a selected participating pharmacy.

**The Benefits of CVS/Caremark Mail Service - SAVE TIME AND MONEY**

- Receive a 90-day supply
- Enjoy convenient delivery to your home (or specified address)
- Take advantage of toll-free Customer Care and Pharmacist Consultation
- Experience easy refill ordering by phone, internet or by mail

**How to Order By Mail**
Ask your doctor to write a prescription for a 90-day supply of your medication. For your first prescription order, complete a CVS/Caremark Mail Service form and mail it along with your copayment and doctor's prescription. New prescriptions may not be phoned in by your doctor. You may order refills by phone or on the internet. For your convenience, Visa, MasterCard, American Express, Discover and personal checks are accepted. (Payment is required at the time you place your order.) You can register on-line at www.caremark.com
or by calling (800)378-9264 .

**Out-of-Area Services**
If you are traveling outside the Central Florida area and need a prescription filled, call CVS/Caremark Customer Care at (800)378-9264.

**Your Identification Card**
You will find your copayment/coinsurance amounts in your OCPS Insurance Handbook. Remember to show your new CVS/Caremark ID card to your pharmacist each time you have a prescription filled.

**Copayment/Coinsurance**
For each prescription you have filled, you will pay an out-of-pocket amount, called a copayment if you are enrolled in either Plan B: Cigna Health Reimbursement Account or
Plan C: Cigna OAP In-Network Plan, or coinsurance if you are enrolled in Plan A: Cigna Local Plus OAP In-Network Plan. For your copayment/coinsurance amount and details about your pharmacy benefits, refer to the Schedule of Benefits in your Medical Plan pages of this handbook.

**Generic Drugs**

- Generic equivalents of prescription drugs will be dispensed if an equivalent is available.
- It is important to note that if you or your physician request a brand-name drug when a generic is available, you will be responsible for 100% of the cost of the medication.

**Why Generic Drugs Cost Less**
Generic drugs have the same active ingredients in the same quantity as their brand name equivalents and they meet the same FDA standards for safety and effectiveness. The difference is that the brand name drug makers can "copy" the formula. Their development costs are relatively low and there are no advertising costs, so the generic drug maker can charge less, which saves you money.

**Questions?**
If you need more information about your pharmacy benefits or formulary information, call CVS/Caremark at (800)378-9264. The formulary is available at www.caremark.com

**Prior Authorization Program**
Certain prescriptions require "clinical prior authorization" or approval before they will be covered. Please contact CVS/Caremark clinical services at (800)378-9264 to request approval. Please have available the name of the medication, physician's name, phone (and fax number, if available), your member ID number and your pharmacy group number (from your ID card). If you have a medication that falls under the Drug Quantity Management program and you would like to request a prior authorization, you may do so by calling the number above.

**Specialty Pharmacy Program**
Certain medications used for treating complex health conditions must be obtained through the Specialty Pharmacy program. The following conditions may require drugs that fall under Specialty Pharmacy which include, but are not limited to: Growth Hormone Deficiency, Multiple Sclerosis, HIV and Viral Hepatitis. Prescriptions for these drugs may be filled only through CVS/Caremark's specialty pharmacy. Please call (800)237-2767 to enroll in this program. For additional information regarding CVS/Caremark's specialty pharmacy, you can visit www.CVSCaremarkSpecialtyRx.com. We also offer the option to ship your medication to your local CVS Retail Pharmacy for pickup.

## *PRESCRIPTION DRUG PROGRAM EXCLUSIONS/LIMITATIONS*

1. Any drug used primarily for cosmetic purposes such as Rogaine (minoxidil) for hair restoration, Renova for skin wrinkles, or any other drug for cosmetic purposes.

2. All medicinal substances (over the counter) which may be dispensed without a prescription including, but not limited to all strengths and all forms of Allegra, Claritin, Zyrtec, Prilosec, Zantac, Axid AR, Pepcid, and Tagamet. Insulin is an exception and is covered. Aspirin (to prevent cardiovascular disease) is an exception and is covered for all plan members ages 45 to 79.

3. All Non-Sedating Antihistamines (NSAs).

4. Prescription drugs with equivalent products also available over the counter. These products are identical in active chemical ingredient, dosage form, strength, and route of administration.

5. Therapeutic devices or appliances, including but not limited to support garments, ostomy supplies and other non-medical substances.

6. All brand-name prescription drugs not on the formulary.

7. All drugs bearing a label: "Caution – limited by federal law to investigational use," or experimental drugs.

8. The refilling of a prescription in the amount greater than that authorized by the prescriber.

9. The refilling of a prescription at a point in time after one year from the date of issuance.

10. The filling or refilling of prescriptions not in compliance with applicable state and federal laws, rules and regulations.

11. Quantities in excess of a 90-day supply (100 pills may be dispensed if packaged in lots of 100).

12. Prescription drugs which may be properly received without change under local, state, or federal programs including workers' compensation.

13. Prescription drugs for medical plan coverage exclusions such as sexual dysfunction or inadequacies, or infertility.

14. Diet medications or medications prescribed for weight control.

15. Abortive contraceptives (e.g., Mifeprex).

16. Impotency medications (e.g., Muse, Edex, Caverject, Viagra, Levitra, Cialis).

17. Fertility drugs, oral and injectable.

18. Oral Fluoride Preps, except for children older than 6 months of age through 5 years old.

19. All vitamins, with the exception of folic acid for women of child-bearing age (e.g. 18 to 45), iron supplements for children ages 6 to 12 months who are at risk for iron deficiency anemia and Vitamin D for all members over the age of 65, prenatal vitamins are covered if enrolled in the well pregnancy program.

20. Nutritional/Dietary Supplements.

21. Medical foods.

22. Homeopathic drugs, all dosage forms including injectables.

23. Diagnostic, testing & imaging supplies (e.g. Tubersol for TB skin test, Radiopaque dye).

24. Prescriptions for Smoking Cessation medications are covered with a day's supply maximum of 90 days per 365 day rolling period.

25. Certain medications may be a part of the CVS/Caremark Valued Formulary. This program is designed to limit medications for both quantity and day's supply based on safe prescribing guidelines from the FDA. Prior Authorizations may be allowed for some of these medications where applicable.

26. Prior Authorizations are required for certain classes of medications before they can be dispensed: For a listing of these medications, please visit www.caremark.com

27. Certain medications under Specialty Pharmacy will require prior authorization prior to filling the medication and can include Step Therapy as well. For a listing of Specialty medications requiring Prior Authorization, please visit www.CVSCaremarkSpecialtyRx.com

28. Certain categories will require Step Therapy. These medications will require that a first line agent is utilized prior to a second line brand agent. For a listing of medications requiring Step Therapy, please visit www.caremark.com

29. Introduction of new medications-- Effective Jan. 1, 2010, new medications coming to the market will be in a "pended" status (that is, not covered under the OCPS plan) until reviewed and approved by the CVS/Caremark Pharmacy and Therapeutic Committee for safety and effectiveness. The CVS/Caremark Pharmacy and Therapeutic Committee is a group of physicians and pharmacists from different specialties who advise a Pharmacy Benefit Management (PBM) company regarding safe and effective use of medications. Additionally, prior to approval, CVS/Caremark Pharmacy and Therapeutic Committee will recommend appropriate Clinical Prior Authorizations, including Step Therapies, for implementation. The Medical Director of the medical and/or behavioral health plan will "sign off" on this recommendation as the final step. CVS/Caremark Pharmacy and Therapeutic Committee still determines formulary/non-formulary status and the medication shall be so placed if/when approved for coverage. Please note that coverage will not be retroactive; that is, medications in this "pended" category will not be covered or reimbursed until approved. Since the CVS/Caremark Pharmacy and Therapeutic Committee meets quarterly, OCPS would not expect this process to take longer than three to four months. Members with questions about the coverage of specific drugs should contact CVS/Caremark Customer Service to check on the status of the drug in question.

30. All branded diabetes glucose monitors and test strips with the exception of OneTouch™ monitors (obtained from manufacturer) and OneTouch™ test strips. To obtain a glucose monitor, you must either obtain a coupon from OCPS Benefits or call CVS/Caremark Customer Care at (800)378-9264**.** If your doctor feels the first-line Step Therapy product (OneTouch™) isn't right for you, your doctor will need to complete a Prior Authorization review for the second-line product by calling CVS/Caremark Customer Care at (800)378-9264. If the Prior Authorization is approved based on the clinical information provided, the second-line non-preferred test strips will be covered. If approved, members in Plan A: Cigna Local Plus OAP In-Network Plan will pay a 50% coinsurance (minimum $120 copay) for a 90-day supply through mail service and members in Plan B: Cigna Health Reimbursement Account Plan or Plan C: Cigna OAP In-Network Plan will pay a $120 copay for a 90-day supply through mail service.

# II. MEDICAL INSURANCE

## E. ORLANDO BEHAVIORAL HEALTHCARE EAP AND BEHAVIORAL HEALTH SERVICES

**(Your Mental Health/Chemical Dependency Benefit For ALL Medical Plans)**

# BENEFITS FOR BEHAVIORAL HEALTH SERVICES

All Behavioral Health Services for eligible OCPS members are provided by Orlando Behavioral Healthcare. These services include Employee Assistance (EAP) and Behavioral Health. Both EAP and Behavioral Healthcare services may be accessed through the Orange County Public Schools' Employee Assistance Program or through Orlando Behavioral Healthcare at 407.637.8080. OCPS members must call Orlando Behavioral Healthcare for pre-authorization of all Mental Health/Chemical Dependency Inpatient and Outpatient services.

Orlando Behavioral Healthcare will provide each member necessary care and treatment of mental and nervous disorders including autism, generally defined, but not limited to ICD-9-CM Mental Disorders Conditions (290-319), DSM-5 or ICD-10-CM when pre-authorized by Orlando Behavioral Healthcare. Subject to the *Behavioral Health Services Exclusions* listed on page 3 of this section.

Medically necessary treatment requiring inpatient psychiatric care, including related hospital inpatient services, physicians, and mental health professionals is provided for up to 30 days per plan year. Pre-authorization by Orlando Behavioral Healthcare is required. Outpatient services provided by licensed psychiatrists, psychologists, or licensed mental health professionals up to 20 visits per plan year for mental health services (autism visits include services provided by Certified Behavioral Analysts. NOTE: Certified Behavioral Analysts do not need to hold a licensure but must be certified in Behavioral Analysis) and 44 visits per plan year for substance abuse are covered when services are deemed reasonable and necessary for crisis intervention, diagnostic evaluation, and treatment. Plan year is October 1$^{st}$ through September 30$^{th}$.

Long-term intensive care services must be pre-authorized by Orlando Behavioral Healthcare and provided in a state-licensed and/or Joint Commission approved facility.

## SCHEDULE OF BENEFITS

| BENEFIT FEATURE | IN-NETWORK | | OUT-OF-NETWORK |
|---|---|---|---|
| **MENTAL HEALTH (M.H.)** | | Maximum*** | |
| Inpatient Psychiatric | 90% coverage | 30 days/yr | Not covered |
| Long Term Intensive Care (LIC)* | 90% coverage | 90 days/yr | Not covered |
| Outpatient (1 – 5 visits) | 100% coverage | N/A | Maximum reimbursement to member $30** |
| Outpatient (6 – 10 visits) | $10/visit (copay) | N/A | Maximum reimbursement to member $30** |
| Outpatient (11 - 20 visits) | $20/visit (copay) | 20 M.H./yr | Maximum reimbursement to member $30** 20 M.H./yr |
| Emergency Intervention | 100% coverage | N/A | Maximum reimbursement to member $30** |
| **AUTISM SERVICES** | | | |
| Outpatient (1 – 5 visits) | 100% coverage | | Maximum reimbursement to member $30** |
| Outpatient (6 – 10 visits) | $10/visit (copay) | | Maximum reimbursement to member $30** |
| Outpatient (beyond 11 visits) | $20/visit (copay) | Maximum plan pays $36,000 per year; $200,000 Lifetime | Maximum reimbursement to member $30** |
| **ALCOHOLISM AND CHEMICAL DEPENDENCY (C.D.)** | | Maximum*** | |
| Inpatient Psychiatric | 90% coverage | 30 days/yr | Not covered |
| Long Term Intensive Care (LIC)* | 90% coverage | 90 days/yr | Not Covered |
| Outpatient (1 – 5 visits) | 100% coverage | N/A | Maximum reimbursement to member $30** |
| Outpatient (6 – 10 visits) | $10/visit (copay) | N/A | Maximum reimbursement to member $30** |
| Outpatient (11 - 44 visits) | $20/visit (copay) | 44 C.D./yr | Maximum reimbursement to member $30** 44 C.D./yr |
| Emergency Intervention | 100% coverage | N/A | Maximum reimbursement to member $30** |

* Long Term Intensive Care services must be pre-authorized by Orlando Behavioral Healthcare and provided in a state-licensed and/or Joint Commission approved facility and by licensed, in-network practitioners. Specially designed Intensive Outpatient Programs using individual sessions in lieu of Intensive Outpatient group sessions will count against the Long Term Intensive Care benefit as a ½ day.

**This amount is the maximum allowable benefit. Any charges in excess will be the member responsibility.

***Benefits up to the maximum allowed are subject to medical necessity.

NOTE: This Schedule of Benefits does not contain all provisions of your benefit plan. A full description of benefits is contained in the Plan Document.

## *BEHAVIORAL HEALTH SERVICES EXCLUSIONS*

1. Inpatient care for mental or nervous conditions exceeding 30 days per plan year.

2. Inpatient care for drug or alcohol abuse exceeding 30 days per plan year.

3. Residential Treatment Center (RTC) care for either mental or nervous conditions and for drug and/or alcohol abuse or addiction.

4. Services provided to satisfy court orders and/or avoid incarceration.

5. Outpatient mental health services exceeding a maximum of 20 visits per plan year.

6. Outpatient services for the treatment of alcoholism, and drug addiction exceeding 44 outpatient visits per plan year.

7. Experimental procedures or procedures which have not been accepted as established standard medical practice.

8. Diagnostically unrelated medical conditions defined as medical consultations, and services not directly related to the treatment of a covered person's mental disorder. These medical conditions may be covered under other medical plan benefits.

9. CT scans, EEG, (inpatient and outpatient) lab and x-ray are excluded unless ordered by Orlando Behavioral Healthcare as part of a covered person's mental health or chemical dependency treatment.

10. Emergency outpatient psychiatric and substance abuse services not certified or provided by Orlando Behavioral Healthcare.

11. Any service or treatment, covered through the mental health/chemical dependency benefit that was not certified nor pre-authorized by Orlando Behavioral Healthcare.

12. Medical evaluation resulting in a psychiatric diagnosis. The medical evaluation may be covered under other medical plan benefits.

13. Any service or treatment covered through the mental health/chemical dependency benefit considered not medically necessary and/or not pre-authorized by Orlando Behavioral Healthcare.

14. Any mental health or chemical dependency service or treatment provided out-of-network that was not certified and/or pre-authorized by Orlando Behavioral Healthcare.

15. Treatment of a Covered Person when the Covered Person or Dependent has caused, or threatened to cause personal injury or physical damage to Orlando Behavioral Healthcare property or personnel.

16. Psychiatric and Substance Abuse treatment services provided outside of Brevard, Lake, Orange, Osceola, Seminole and Volusia Counties, Florida unless in the event of an emergency, or pre-authorized by Orlando Behavioral Healthcare.

17. Treatment for autism that is not pre-authorized by Orlando Behavioral Healthcare.

18. Treatment for autism exceeding $36,000 per plan year.

19. Treatment for Intellectual Disability except for the acute secondary psychiatric symptoms.

20. Treatment for obesity or weight loss.

21. Treatment of a Covered Person when the Covered Person or Dependent has demonstrated noncompliance with or non-adherence to recommended treatment by Orlando Behavioral Healthcare.

22. For experimental, investigational or unproven services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined to be: a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or b. The subject of review or approval by an Institutional Review Board for the proposed use; or c. The subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or d. Not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

23. Illness for which the covered person is entitled to benefits under any worker's compensation law or act, or accidental bodily injury arising out of or in the course of the covered person's employment or services rendered by any governmental program (i.e., V.A. hospital) unless there is a legal obligation to pay for coverage.

24. Education, training, and bed and board while confined to an institution which is primarily a school or other institution for training; a place of rest, a place for the aged, or for custodial care.

25. Health Services and associated expenses for bariatric procedures/surgeries intended primarily for the treatment of morbid obesity or weight loss, including but not limited to gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw and health services of a similar nature.

26. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

# II. MEDICAL INSURANCE

**F. ALTERNATIVE TO MEDICAL INSURANCE**

**G. ACCEPTANCE/WAIVER OF MEDICAL INSURANCE FOR PART-TIME EMPLOYEES**

## II. MEDICAL INSURANCE
## F. ALTERNATIVE TO MEDICAL INSURANCE

The following option is available to employees with other group medical coverage (ex. their spouse's/domestic partner's medical plan). Eligible employees may select this alternative online through Employee Self Service. The alternative replaces the medical care benefits previously described. The precertification program does not apply to this alternative.

**This is an OCPS-paid benefit (no employee cost to full-time or part-time employees).**

***DISABILITY/VISION PLAN***

**Disability Benefit** Available for employees, not for dependents

**Monthly Benefit** ..... ……Maximum $1,500
(Not to exceed 66 2/3 percent of your annual base salary)

Elimination Period (Waiting Period)……...…..……...14 days

The above disability plan is underwritten by Lincoln Financial Group. An outline of benefits is included in this handbook.

**Vision Benefit** Available for employees and dependents

Benefits are payable under the Humana Specialty Benefits Vision Plan outlined in this handbook.

## II. MEDICAL INSURANCE

## G. ACCEPTANCE/WAIVER OF MEDICAL INSURANCE FOR PART-TIME EMPLOYEES

OCPS pays a portion of the rate of the Employee-only medical insurance for part-time benefited employees working between 17.5 and 24.9 hours per week. These part-time employees have the option of paying the remaining portion of the cost for their own medical insurance, or declining coverage. If part-time employees decline coverage and later become full-time, they can accept the OCPS medical insurance at that time. It is the employee's responsibility to contact Insurance Benefits if their status changes from part-time to full-time.

# III. TERM LIFE INSURANCE

**A. OCPS-PAID TERM LIFE INSURANCE**

**B. DEPENDENT TERM LIFE INSURANCE**

# III. TERM LIFE INSURANCE

## A. OCPS-PAID TERM LIFE INSURANCE

(Including Accidental Death and Dismemberment)

***BASIC BENEFIT***

One-hundred percent of your base annual salary, with a minimum benefit of $7,500 and a $500,000 maximum. Included is an Accidental Death and Dismemberment (AD&D) plan.

***REDUCTIONS***

Your Basic Life Insurance benefit will be reduced as follows:

- Less than age 70, no benefit reduction.
- At age 70, benefits will reduce by 35% of the original amount.
- At age 75, benefits will reduce an additional 15% of the original amount.

***BENEFIT***

If covered persons die while insured for employee life insurance, Lincoln Financial Group will pay the benefit to their beneficiary according to the terms of this policy, after we receive satisfactory proof of death.

***ACTIVELY AT WORK***

If an employee is not actively at work on the date coverage is to become effective, the employee will not become insured until the day they return to full-time, active duty. To be considered actively at work an employee must be performing his or her regular job duties for the employer. If an employee is not at work on the date the insurance would otherwise start because of vacation, holiday, or because it is not a regular workday, the insurance will start on that day if the employee is not disabled on that day, and he or she was actively at work on his or her last scheduled work day.

***CONTINUATION***

This coverage may be continued according to the terms of this policy when covered persons are no longer working due to:

1. a total disability (only upon approval of waiver of premium);
2. an approved leave of absence (other than for military service);
3. a temporary lay-off; or
4. an approved sabbatical leave.

***TERMINATION OF COVERAGE***

Your insurance will end on the earliest of:

1. the date this policy terminates;
2. the last day of the calendar month during which the employee's job classification is no longer eligible for the benefit;
3. the last day of the calendar month during which the employee leaves eligible class;
4. with respect to contributory insurance, the last day of the calendar month during which their last premium payment was made;
5. the last day of the calendar month during which they enter active military service, except for temporary duty of; 30 days or less or
6. the last day of the calendar month during which their active full-time employment with the employer ends.

If covered person's employment ends because of lay-off, strike, leave of absence (other than for active military service) or disability, the employer may continue their insurance by continuing to remit the appropriate premium. Coverage may not be continued for more than 24 months of an approved leave of absence.

***EXTENSION OF DEATH BENEFIT***

If covered persons become totally disabled before age 70 and while insured under this plan, their employee insurance will be continued without further payment of premium. However, covered persons must continue to pay premiums until Lincoln Financial Group approves their total disability. To be considered totally disabled, covered persons must, because of injury or illness, be unable to do any work for which they are reasonably qualified by education, training, or experience.

Covered persons must submit to Lincoln Financial Group the fully completed proof of total disability form available from the employer. Lincoln Financial Group must receive the fully completed form: (a) after covered persons have been disabled for 6 months; but (b) no later than 24 months after their active work ceases due to disability. **It is very important that this form be submitted to Lincoln Financial Group within the specified time limit.**

How does Lincoln Financial Group define disability?
You are disabled when Lincoln Financial Group determines that:

- during the elimination period, you are not working in any occupation due to your injury or sickness; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any occupation for which you are reasonably fitted by training, education or experience.

After the first 2 years of total disability, proof must be given each year thereafter, but no more than once in any 12-month period. If covered persons die while the premium is being waived, proof is required that they were totally disabled continuously between the time premiums ceased and the date of their death. This proof must be furnished when the claim for life insurance benefits is filed.

If a conversion policy was issued to covered persons, it must be returned without claim before total disability can be approved. Covered persons will receive a return of the premiums they paid for the conversion policy. If covered persons die before the conversion policy is returned, its benefit will be deducted from the amount payable under this policy. The amount of insurance continued is the amount of covered persons' insurance in effect on the day before they became disabled. This amount will be subject to any age reductions that are specified in Section II – Schedule of Insurance. Covered Persons' amount of insurance will not increase while premiums are waived.

Waiver of premium will cease when any of the following takes place:

1. Covered persons cease to be totally disabled;
2. They fail to furnish proof of total disability when required; or
3. They refuse a required medical examination.
4. They reach Social Security Normal Retirement Age (SSNRA)

When waiver of premium ceases, one of the following will apply:

1. Covered persons return to work with the employer: if this happens, their eligibility for coverage and the terms of coverage will be governed by the policy then in effect; or
2. Covered persons do not return to work with the employer: if this happens, they may convert their insurance to an individual policy according to the conversion privilege described below.

***CONVERSION PRIVILEGE***

When coverage ends under the plan, covered persons can convert to an individual life policy without evidence of insurability. Covered persons may convert their employee life insurance to an individual policy in the following situations:

1. If their life insurance ends because their employment ends, or because they leave the eligible class, they may convert all or a part of their insurance to an individual policy; or
2. If their life insurance ends because this policy ends, they may convert to an individual policy under the following conditions:
   a) their insurance must have been in effect for at least 5 years. Coverage under a previous group life insurance policy with the employer will apply toward the 5-year period;
   b) the maximum amount they may convert is the lesser of: (i) the amount of their insurance under this policy, minus any other group life insurance for which they become eligible within 31 days after this policy ends or is amended, or (ii) $10,000; or
3. If their life insurance was being continued because of disability, and that continuation then ceases, they may convert all or part of their insurance, unless they return to work with the employer and they are insured by Lincoln Financial Group as an active employee. However, if this policy has already terminated when their continuation ceases, then their conversion privilege is limited as described in (a) and (b) of item 2 above.

To convert, application must be made in writing and the first premium paid within 31 days after the insurance ends (the conversion period). Evidence of Insurability is not required. The conversion policy will become effective at the end of the conversion period. If covered persons die during the conversion period, Lincoln Financial Group will pay a life insurance benefit equal to the maximum amount that could have been converted.

***PORTABILITY (CONTINUATION RIGHTS) BENEFIT FOR LIFE INSURANCE AND AD&D FOR EMPLOYEE***

Portability is a continuation of the Group Life coverage under certain circumstances.

If employment ends with or they retire from their Employer or if they are working less than the minimum number of hours, which ends eligibility under the group plan, they may elect portable coverage for themselves and their dependents.

The Employee is not eligible to apply for portable coverage if he/she has an injury or sickness which has a material effect on life expectancy.

The portable insurance coverage will be the current coverage and amounts that the employee is insured for under the Employer's group plan. The maximum amount of coverage that can be ported is the highest amount of life insurance available for employees under this plan.

If the current amount of life insurance under the plan is more than $5,000, the minimum amount of coverage that can be ported is $5,000. If the current amount of life insurance under the plan is less than $5,000, then the lesser amount can be ported. The amount of life insurance will reduce or cease at any time it would reduce or cease for their eligible group if they had continued in active employment with their Employer.

The ported coverage will have the same benefit reductions at certain ages as the Basic Life Insurance. If the group policy is cancelled, the Conversion Privilege is available. Ported coverage will terminate after 36 months and the Conversion Privilege is available.

They must apply for portable coverage and pay the 1st premium within 31 days after the date:

- coverage ends or they retire from their Employer; or
- they begin working less than the minimum number of hours as described under Eligible Groups in this plan.

***ACCELERATED DEATH BENEFIT***

If covered persons become terminally ill while their life insurance is in effect, they may apply to receive a portion of their insurance benefit while they are living. They may elect any amount up to a percentage of their employee life insurance benefit, after any age reduction, as of the day Lincoln Financial Group approves their application. Covered persons can elect up to seventy-five percent of the life benefit with a maximum payment of $250,000 for terminal illness expected to result in death within 12 months.

Covered person's applications must be accompanied by a physician's written certification that they are terminally ill. Covered person's applications must be satisfactory to Lincoln Financial Group. If Lincoln Financial Group approves covered person's applications, Lincoln Financial Group will pay the living benefit provided they are living at that time. Lincoln Financial Group will make only one such living benefit payment during their lifetime.

Upon the covered person's death, any life insurance benefit that would otherwise be paid will be reduced by the amount of the living benefit, including any living benefit paid under a previous plan of group life insurance with the employer. Covered persons must be insured at the time of death in order to be eligible for the remaining benefit. Premiums for the remaining death benefit must be paid, unless they are eligible for waiver under a disability provision elsewhere in this policy.

If covered persons elect to convert their insurance under the conversion privilege, the amount they would otherwise be eligible to convert will be reduced by the amount of the living benefit, before deducting the interest charge, including any living benefit paid under a previous plan with the employer.

The living benefit will not be paid if:

1. the amount of covered person's life insurance benefit is less than the minimum required;
2. covered persons have assigned their life insurance;
3. Lincoln Financial Group has been notified that some portion of covered person's life insurance benefit is to be paid to a former spouse as part of a divorce agreement; or
4. covered person's terminal illness is a result of attempting suicide or an intentionally self-inflicted injury.

Please note that **covered persons may have to pay income tax on the living benefit**. They should consult their personal tax advisor before requesting this benefit.

***ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (AD&D)***

(This benefits applies to the insured employee only)

You are eligible for this benefit if you are accidentally injured while your insurance is in effect and the injury directly results in one of the following total losses which occurs: 1) without other causes; and 2) within 365 days of the accident.

***BENEFIT (Principal Sum)***

One-hundred percent of your base annual salary, with a minimum benefit of $7,500 and a $500,000 maximum. The AD&D benefit is a percentage of the principal sum based on the type of loss as shown in this table below:

| **Accidental Loss For Covered Accidents:** | **Percentage of Principal Sum** |
|---|---|
| Life | 100% |
| Both hands or both feet or sight of both eyes | 100% |
| One hand and one foot | 100% |
| Either hand or foot and sight of one eye | 100% |
| One hand or one foot | 50% |
| Sight of one eye | 50% |
| Quadriplegia | 100% |
| Paraplegia, or hemiplegia | 100% |
| Maximum any one accident | 100% |
| **Accidental Loss For Common Carrier Accident*:** | **Percentage of Principal Sum** |
| Life | 200% |
| Both hands or both feet or sight of both eyes | 200% |
| One hand and one foot | 200% |
| Either hand or foot and sight of one eye | 200% |
| One hand or one foot | 100% |
| Sight of one eye | 100% |
| Quadriplegia | 200% |
| Paraplegia, or hemiplegia | 200% |
| Maximum any one accident | 200% |

*"Common Carrier Accident" means a covered accidental bodily injury, which is sustained while riding as a fare paying passenger (not a pilot, operator or crew member) in or on, boarding or getting off from a "Common Carrier." "Common Carrier" means any land, air or water conveyance operated under a license to transport passengers for hire.

***REDUCTIONS***
Your AD&D Insurance benefit will be reduced as follows:

- Less than age 70, no benefit reduction.
- At age 70, benefits will reduce by 35% of the original amount:
- At age 75, benefits will reduce an additional 15% of the original amount

Accidental injury means a bodily injury that is a direct result of an accident and not related to any other cause.

The benefit for the accidental loss of covered person's life will be paid to the beneficiary. All other benefits will be paid to covered persons.

**Seat Belt/Air Bag Benefit:** (Applies to AD&D coverage only)

If you or your insured dependent(s) die in a car accident and are wearing a properly fastened seat belt and/or are in a seat with an air bag, an amount will be paid in addition to the AD&D benefit.

Benefit Amount:
Seatbelt: $10,000 or 10% of the principle sum, whichever is less.
Airbag: $10,000 or 10% of the principle sum, whichever is less.

**Repatriation Benefit** (Applies to AD&D coverage only)

Lincoln Financial Group will pay up to $5,000 additional benefit for preparation and transportation of body to a mortuary, if the loss occurs at least 100 miles away from your principal place of residence.

**Loss is defined as follows:**

1. Loss of a hand means complete severance through or above the wrist joint;
2. Loss of a foot means total severance at or above the ankle joint;
3. Loss of sight means total and irrevocable loss of sight in that eye
4. Total and irreversible paralysis of both arms and legs for quadriplegia;
5. Total and irreversible paralysis of both legs for paraplegia;
6. Total and irreversible paralysis of the arm and leg on the same side of the body for hemiplegia.

***AD&D EXCLUSIONS***

Benefits are not payable for accidental losses caused by, contributed to by, or resulting from:

- Suicide, self destruction while insane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- Active participation in a riot.
- An attempt to commit or commission of a crime under state or federal law.
- Being intoxicated (blood alcohol is greater than the legal limit).
- The use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- War, declared or undeclared, or any act of war.
- Travel or flight in any aircraft, including balloons and gliders; except as a fare paying passenger on a regularly scheduled flight.

## III. TERM LIFE INSURANCE

## B. DEPENDENT TERM LIFE INSURANCE

***MAXIMUM BENEFIT***

| | | | |
|---|---|---|---|
| Class I: | If your base annual salary is $20,000 or more, the benefit | | |
| | For your spouse/domestic partner | $10,000 | and/or |
| | For each eligible unmarried child at least 6 months old | $5,000 | |
| Class II: | If your base annual salary is at least $15,000, but less than $20,000, the benefit | | |
| | For your spouse/domestic partner | $7,500 | and/or |
| | For each eligible unmarried child at least 6 months old | $3,750 | |
| Class III: | If your base annual salary is at least $10,000, but less than $15,000, the benefit | | |
| | For your spouse/domestic partner | $5,000 | and/or |
| | For each eligible unmarried child at least 6 months old | $2,500 | |
| Class IV: | If your base annual salary is less than $10,000, the benefit | | |
| | For your spouse/domestic partner | $3,750 | and/or |
| | For each eligible unmarried child at least 6 months old | $1,875 | |

For all classes, the benefit for each child 14 days to 6 months is $1,000.

***GENERAL INFORMATION***

***ELIGIBILITY***

Employees covered under OCPS-paid term life insurance Plan IIIA, may select Plan IIIB, the dependent term life insurance.

***DEPENDENT***

A Dependent is an Insured Person's:

1. spouse who is not legally separated from the Insured Person;
2. same-sex domestic partner as defined by OCPS;
3. unmarried child at least 14 days but less than 19 years of age;
4. unmarried child less than 25 years of age, if attending an accredited educational institution for the minimum credit hours required to maintain full-time student status there; or
5. unmarried child who is totally and permanently disabled and who became so disabled prior to reaching 19 years of age.

A legally adopted child is considered the Insured Person's child from the date of placement in the Insured Person's home for an agency adoption; or from the date the adoption petition is filed, if later, for a private adoption.

In addition to naturally born and legally adopted children, the word "child" includes an Insured Person's stepchild, foster child or domestic partner's child provided the child resides in the Insured Person's household and is dependent on the Insured Person for principal support.

The term Dependent does not include anyone serving in the armed forces of any state or country, except for duty of 30 days or less for training in the Reserves or National Guard.

***BENEFIT***

If an eligible dependent dies while insured for dependent life insurance, Lincoln Financial Group will pay covered persons the benefit according to the terms of this policy, after Lincoln Financial Group receives satisfactory proof of death. If covered persons are not living, Lincoln Financial Group will pay the benefit to the covered person's estate.

***COVERAGE FOR TOTALLY DISABLED DEPENDENT***

If a Dependent is confined in a hospital on the date his or her Dependents Life Insurance would otherwise take effect, then Dependents Life Insurance for that Dependent will not take effect until ten days after final discharge from the hospital.

***CONVERSION PRIVILEGE***

When coverage ends under the plan, covered dependents can convert to an individual life policy without evidence of insurability. The insurance on an eligible dependent may be converted to an individual policy if the life insurance on the dependent ends because:

1. Covered persons die, or their employment terminates;
2. Covered persons leave the eligible class; or
3. The dependent is no longer eligible;

All or part of the dependent's insurance may be converted to an individual policy.

If the life insurance on the dependent ends because this policy ends or because this policy is amended, then all or part of the dependent's insurance may be converted to an individual policy under the following conditions:

1. The life insurance on the dependent must have been in effect for at least 5 years. Coverage under a previous group life insurance policy with the employer will apply toward the 5-year period; and
2. The maximum amount that may be converted is the lesser of: (i) the amount of dependent insurance under this policy, minus any other group life insurance for which the dependent becomes eligible within 31 days after this policy ends or is amended, or (ii) $10,000.

To convert, application must be made in writing and the first premium paid within 31 days after the insurance ends (the conversion period). Evidence of insurability is not required providing application is made and premium is paid within the appropriate time period. The conversion policy will be effective at the end of the conversion period.

If the dependent dies during the conversion period, Lincoln Financial Group will pay a life insurance benefit equal to the maximum amount that could have been converted.

The individual policy may be on any form we then issue for the amount chosen, except term insurance. Waiver of premium, accidental death, or other optional provisions or riders are not available under the individual policy.

***PORTABILITY (CONTINUATION RIGHTS) BENEFIT FOR LIFE INSURANCE FOR SPOUSE/DOMESTIC PARTNER AND CHILDREN***

Portability is a continuation of Dependent Life coverage under certain circumstances. If employment ends with or employee retires from their Employer or if employee is working less than the minimum number of hours, which ends eligibility under the group plan, they may elect portable coverage for themselves and their dependents.

**If the Employee does not elect portable coverage for his or herself, the spouse/domestic partner or children cannot apply for portability coverage.** In the case of the employee's death, the insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse/domestic partner also becomes insured for portable coverage.

The spouse/domestic partner or child is not eligible to apply for portable coverage if he/she has an injury or sickness which has a material effect on life expectancy.

The maximum amount of portable coverage for a spouse/domestic partner is the highest amount of life insurance available for spouses/domestic partners under this plan.

The maximum amount of portable coverage for a child is the highest amount of life insurance available for children under this plan.

If the current amount of dependent life insurance under the plan is more than $1,000, the minimum amount of coverage that can be ported is $1,000. If the current amount of life insurance under the plan is less than $1,000, then the lesser amount can be ported.

The ported coverage will have the same benefit reductions at certain ages as the Basic Life Insurance. If the group policy is cancelled, the Conversion Privilege is available.

Spouse/domestic partner and Dependents must apply for portable coverage and pay the 1st premium within 31 days after the date:

- the employee coverage ends or employee retires from their Employer; or
- employee begins working less than the minimum number of hours as described under Eligible Groups in this plan.

***BENEFICIARY CONNECT SERVICES***

Lincoln Financial Group offers free beneficiary assistance to help you cope with this difficult emotional time. Services include:

- Unlimited phone contact with grief counselors and legal advisors
- Up to 6 sessions or equivalent professional time for grief and/or legal consultation
- Memorial planning assistance
- Child and elder care referrals
- Other support services including financial counseling and moving/relocation services

***WORLDWIDE EMERGENCY TRAVEL ASSISTANCE SERVICES*** [1]

Whether your travel is for business or pleasure, our worldwide emergency travel assistance program is there to help you when an unexpected emergency occurs. With one phone call anytime of the day or night, you, your spouse/domestic partner and dependent children can get immediate assistance anywhere in the world.[2]

Emergency travel assistance is available to you when you travel to any foreign country, including neighboring Canada or Mexico. It is also available anywhere in the United States for those traveling more than 100 miles from home. Your spouse/domestic partner and dependent children do not have to be traveling with you to be eligible. However, spouses/domestic partners traveling on business for their employer may not covered by this program.

**[1,2]** All Worldwide emergency travel assistance must be arranged by Medex, which pays for all services it provides. Medical expenses such as prescriptions or physician, lab or medical facility fees are paid by the employee or the employee's health insurance. Worldwide emergency travel assistance services are provided by Medex and are available with selected Lincoln insurance offerings. Exclusions, limitations and prior notice requirements may apply, and service features, terms and eligibility criteria are subject to change. The services are not valid after termination of coverage and may be withdrawn at any time. Please contact your Lincoln representative for full details.

*This plan highlight is a summary provided to help you understand your insurance coverage with Lincoln Financial Group. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

# IV. GROUP UNIVERSAL LIFE INSURANCE

## IV. GROUP UNIVERSAL LIFE INSURANCE
**Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group (Securian)**

**What is Group Universal Life Insurance?**
Group Universal Life Insurance (GUL) is a group life insurance plan that offers the added advantage of a Cash Accumulation Fund, making it a flexible financial planning tool. Participants may adjust their life insurance coverage and the amount of their contributions to the Cash Accumulation Fund as their needs change. Money in the Cash Accumulation Fund earns a competitive interest rate that grows income tax-deferred. You have access to your money at any time through loans or withdrawals. Loans and withdrawals will reduce both the policy cash value and death benefit.

**Eligibility**
For initial coverage or increases in coverage to become effective, the employee must be actively at work on the initial effective date and their spouse and children must not be hospitalized or confined because of illness or disease.

**COVERAGE AMOUNTS AVAILABLE FOR**

**EMPLOYEE**

$10,000 increments. The minimum benefit is $10,000; the maximum benefit is five times your annual salary rounded to the next higher $10,000, or $1,000,000, whichever is less. ***Maximum amount of insurance available without a medical statement for NEWLY HIRED/NEWLY ELIGIBLE employees who enroll within 31 days after becoming eligible:*** Up to two times your annual salary rounded to the next higher $10,000 or $200,000, whichever is less.

Employees can elect or increase coverage on a guaranteed basis within 31 days of a qualified status change (i.e. marriage, birth, adoption). Employees may elect or increase coverage one $10,000 increment, up to a new total maximum of two times their annual salary rounded to the next higher $10,000, or $200,000, whichever is less without health questions.

During this year's annual enrollment, if you're ***not*** **currently enrolled** in the GUL plan, you can obtain coverage for yourself in increments of $10,000, up to a maximum of one times your annual salary or $100,000, whichever is less, without health questions.

If you are **currently enrolled** in the GUL plan, you can increase coverage (in increments of $10,000) by one times your annual salary, up to $200,000 or two times you annual salary, whichever is less, without health questions.

**SPOUSE/DOMESTIC PARTNER**

$10,000 increments. The minimum is $10,000; the maximum benefit is three times the employee's annual salary, rounded to the next higher $10,000, or $100,000, whichever is less. The lawful spouse/domestic partner must not be legally separated from the employee. The spouse/domestic partner is not eligible for insurance as an employee. For the coverage to become effective, the employee must be actively at work and the spouse/domestic partner must not be hospitalized or confined because of illness or disease. The maximum amount of insurance available without a medical statement for spouses/domestic partners of NEWLY HIRED/NEWLY ELIGIBLE employees and spouses/domestic partners who enroll within 31 days after date of marriage is $10,000. **Any spouse/domestic partner currently insured and wanting to increase coverage or any spouse/domestic partner who enrolls after the 31 day eligibility period is required to submit a medical statement for ANY amount of coverage and be approved before coverage will be effective.**

**CHILD** $5,000 or $10,000 term insurance, convertible to full GUL coverage up to five times the term amount due to loss of dependent eligibility. Eligible children are the employee's natural, adopted, step, domestic partner's children, foster children and children for whom the employee or spouse/domestic partner is a legal guardian. Children are eligible from live birth (stillborn and unborn children are not eligible) to the end of the calendar year in which the child attains age 26. Children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on the employee for more than one-half of their support and maintenance. If an employee's first eligible child dies within 31 days of birth, but prior to the employee enrolling for child life coverage, Securian will pay a benefit of $5,000. For coverage to become effective, the employee must be actively at work and the dependent children must not be hospitalized or confined because of illness or disease.

**Duplication of coverage**
An employee cannot also be covered as a spouse/domestic partner or child of another employee. A child may only be covered by one parent if both are employees of Orange County Public Schools (OCPS).

**Suicide Exclusion**
If a participant commits suicide within the first two years of the effective date of his/her GUL coverage, the death benefit will be limited to a refund of the premium. In addition, if a participant commits suicide within two years of the effective date of an increase in coverage, the death benefit for the increased coverage amount will be limited to a refund of the premium for the increased amount.

**Accelerated Death Benefit**
In an effort to help an insured who is terminally ill—with a life expectancy of 12 months or less—to meet medical and other personal needs, the plan will pay up to 100% of the value of their life insurance while the Insured is still living. The maximum benefit is $1,000,000 and the minimum is $10,000. There is no restriction on how a person spends this money. For example, it can be used to pay living expenses or uninsured medical expenses, or to fulfill a desire to travel. Benefits may be taxable, and future legislation may place limits on this benefit.

**The Group Universal Life (GUL) program offers the following advantages to you**

***Portability***
Participating employees, spouses/domestic partners and dependent children may continue their coverage on a direct-bill basis if the employee terminates employment or retires after the plan effective date or if a spouse/domestic partner or child no longer meets the eligibility requirements. Minimum rates (cost of insurance) may increase in the future. For more information regarding portability, please contact Securian at 1-800-843-8358.

***Cash Accumulation Fund***
The cash value accumulated in the Cash Accumulation Fund will earn a competitive interest rate that is income tax deferred. The rate can change monthly, but it will go no lower than 3.0. Participants will only pay taxes on the interest earned if they withdraw more than their total contributions (cost of insurance plus Cash Accumulation Fund contributions).

To build the cash value, the participant determines how much extra money to contribute to the plan beyond the minimum premium, which covers the cost of life insurance.

***Easy Access to Cash***
The money in the Cash Accumulation Fund is the participant's to use for whatever he/she wishes. The participant can borrow against the money in their Cash Accumulation Fund or make an outright withdrawal.

- There is no withdrawal transaction fee. The minimum withdrawal amount is $100, and the maximum amount is the total cash value less any outstanding loans.
- Any contribution increase and/or lump-sum contributions you make are subject to Internal Revenue Code maximum guidelines. **Please refer to the Cash Accumulation Fund section for details.**
- If a participant elects to borrow money, the loan rate is 8% annually, and the participant can arrange their own repayment schedule. While the loan remains unpaid, interest credit to the borrowed cash value is 6%. Loan repayments, principal and interest, are payable directly to Securian, not through payroll deduction. If an outstanding loan balance exists at the time of death, the outstanding loan balance including the unpaid interest, will be deducted from the death benefit.

***Flexibility***
The Group Universal Life plan lets the participant control their coverage amounts and Cash Accumulation Fund contributions.

- If you wish to increase your cash value, you can easily increase your contributions.
- You can reduce your contributions or stop them completely. If you need to temporarily stop your monthly payments, the cost for your coverage can be automatically withdrawn from your Cash Accumulation Fund, if you have sufficient cash value. You can start payment again at any time.

***Questions?***
Call the Securian Customer Service Center: 1.800.843.8358 Monday through Friday, 7 a.m. to 6 p.m. Central Time.

**Designing Your Plan**

***For You and Your Spouse/Domestic Partner***
Designing a Group Universal Life Plan for you and your spouse/domestic partner involves two simple steps. First, select the amount of life insurance coverage you and your spouse/domestic partner would like to have. Second, decide if you and/or your spouse/domestic partner would like to participate in a Cash Accumulation Fund and the contribution amount. Once you design the Group Universal Life plan that's right for you, use the rate page to determine your monthly contribution.

***For Your Children***
$5,000 or $10,000 of term insurance is also available for all your dependent children for one low, fixed premium of $0.92 or $1.84 per month. This one premium covers all your dependent children, no matter how many you have. When your children no longer qualify as dependents due to age or marriage, they may convert from term coverage to their own Group Universal Life Insurance plans, without providing medical evidence of good health within 90 days of the date he or she is no longer eligible. Be sure to check the appropriate box on the Group Universal Life enrollment form if you want this coverage.

| **Here's How to Design Your Plan** | | | EMPLOYEE | | SPOUSE/ DOMESTIC PARTNER |
|---|---|---|---|---|---|
| 1. | Indicate the amount of insurance desired (Enter this amount on the enrollment form.) | | $_____ | | $_____ |
| 2. | Divide the insurance amount you selected by $10,000 to determine how many "units" of insurance you'll purchase (Amount of insurance ÷ $10,000). | ÷ | $10,000 | ÷ | $10,000 |
| | | = | $_____ units | = | $_____ units |
| 3. | Use Rate Chart(s) to determine the monthly Cost of Insurance. Find your age and your spouse's/domestic partner's age and enter the appropriate rate per $10,000 shown. | = | $_____ rate per $10,000 | = | $_____ rate per $10,000 |
| | Multiply by the number of units of insurance from Step 2. | X | $_____ units | x | $_____ units |
| | | = | $_____ Cost of Insurance | = | $_____ Cost of Insurance |
| 4. | Decide how much you would like to contribute above the Cost of Insurance to the Cash Accumulation Fund for you and/or your spouse/domestic partner on a monthly basis. You may contribute any amount from $1 up to the maximum allowed by IRC (Internal Revenue Code) | | $_____ Contribution to Cash Accumulation Fund | | $_____ Contribution to Cash Accumulation Fund |
| 5. | To determine your total monthly contribution, add the following: | | $_____ (Step 3) | | $_____ (Step 3) |
| | Cost of Insurance | | $_____ (Step 4) | | $_____ (Step 4) |
| | Contribution to the Cash Accumulation Fund | + | $_____ | + | $_____ |
| | Add $.92 or $1.84 to you or your spouse's/domestic partner's monthly contribution if you select dependent child(ren) coverage. | + | $_____ | + | $_____ |
| | **TOTAL MONTHLY CONTRIBUTION** | = | **$_____** | = | **$_____** |

## Monthly Cost of Insurance

Use these rates to determine the monthly cost of life insurance. To determine the cost of coverage, find your age or your spouse's/domestic partner's age in the left column and read across to find the monthly cost of insurance for each $10,000 of coverage. These rates do not reflect any money going into the Cash Accumulation Fund.

| **Monthly Cost of Insurance – Employees or Spouses/Domestic Partners<br>Deductions are taken over 10 months (September through June) each plan year<br>for 12 months of coverage** | |
|---|---|
| ***Age of Employee or Spouse/Domestic Partner** | **Monthly Cost of Insurance (Rates per $10,000)** |
| Less than 25 | $0.44 |
| 25-29 | $0.54 |
| 30-34 | $0.70 |
| 35-39 | $0.78 |
| 40-44 | $0.88 |
| 45-49 | $1.34 |
| 50-54 | $1.98 |
| 55-59 | $3.70 |
| 60-64 | $5.68 |
| 65-69 | $10.92 |
| 70-74 | $17.70 |

*Your age for calculating monthly premium will be updated on each plan anniversary date, October 1.
Individual rates apply to ages 75 and above.

The rates listed above will be deducted in September for an October 1, 2016 effective date. Rates are subject to change but will not exceed the guaranteed maximum cost of insurance shown in your certificate. If you terminate active employment, higher costs may apply in the future.

**Cash Accumulation Fund**
Contributions to the Cash Accumulation Fund are optional and determined by you. Maximums are based on Internal Revenue Code (IRC) limits and are subject to a 3% charge to cover administrative fees and premium tax. Since contributions are subject to very specific IRC guidelines, dependent upon your age, cost of insurance, and effective date of your certificate, it is recommended that you contact the Securian Customer Service Center, where a Service Representative will calculate the maximum contribution amount for you. Call 1.800.843.8358, Monday through Friday, from 7:00 a.m. to 6:00 p.m., Central Time. You must enroll for life insurance to contribute to the Cash Accumulation Fund.

**Portability**
Participating employees, spouses/domestic partners and dependent children may continue their coverage on a direct-bill basis if the employee terminates employment or retires after the plan effective date or if a spouse/domestic partners or child no longer meets the eligibility requirement. Minimum rates (cost of insurance) may increase in the future. For more information regarding portability, please contact Securian at 1.800.843.8358.

**Access to a Suite of Additional Resources**
The following services are available to employees covered under Minnesota Life Insurance Company group life insurance policies and their spouses and dependent children.

There is no additional fee or enrollment for the services beyond the group life insurance program. Just access these resources as you need them.

**Travel Assistance Services –** RedpointWTP LLC (Redpoint) provides travel assistance services to all active U.S. employees covered under our group life insurance policies and their spouses and dependents. The services are available 24/7/365 for emergency assistance and transport when traveling 100 or more miles away from home.

For service terms and conditions, and pre-trip information visit **www.LifeBenefits.com/travel** or call 1-855-516-5433 in the U.S. and Canada. From other locations, you can call collect to +1-415-485-4677.

**Legal, Financial and Grief Resources** –Lifeworks provides U.S. active employees covered under our group life insurance policies, and their spouses and dependents, access to counseling professionals and related resources and referrals in each of the three areas. Contact Lifeworks at 1-877-849-6034 or visit **LifeWorks.com** (user name: lfg, password: resources).

**Legacy Planning Resources** – Active and retired employees covered under our group life insurance policies, and their families, can access resources to help them deal with the loss of a loved one or to plan for their own passing. These resources are available at **LegacyPlanningResources.com**.

The following service is available to beneficiaries of employees and spouses covered under Minnesota Life Insurance Company group life insurance policies. Access information is provided with claims payment. The program is optional.

**Beneficiary Financial Counseling** – PricewaterhouseCoopers provides Beneficiary Financial Counseling to beneficiaries of our group life insurance plans. The independent and objective financial counseling resources are available at a time when they are needed most. The resources are available to beneficiaries who receive proceeds of $25,000 or more.

Services provided by Lifeworks, RedpointWTP LLC, PricewaterhouseCoopers LLP are their sole responsibility. The services are not affiliated with Minnesota Life Insurance Company or its group contracts and may be discontinued at any time. Certain terms, conditions and restrictions may apply when utilizing the services. To learn more, visit the appropriate website included above.

# V. DISABILITY INSURANCE

## V. DISABILITY INSURANCE

***WHAT IS DISABILITY INSURANCE?***

Disability insurance replaces a portion of your income if you become disabled and unable to work. You may select the benefit level you wish to receive, and your premiums will be based on the level of protection you select. The disability plan offered to OCPS employees is the Lincoln Educator Income Protection Plan.

***ELIGIBILITY***

You are eligible for coverage if you are a full-time employee working 25 hours or more per week or a regular part-time active employee working a minimum of 17.5 hours per week, following a waiting period of 59 days. The date you are eligible for coverage is the later of: the plan effective date; or the day after you complete the waiting period.

New employees who elect disability insurance during their initial enrollment period, proof of good health will not be required. If you are absent from work due to injury, sickness, temporary layoff or leave of absence on the date of your effective date of coverage, coverage will begin on the date you return to active employment.

***UNDERWRITING GUIDELINES***

**New Hires:** New Hires can sign up for coverage within 60 days of their date of hire and receive up to a $7,500 monthly benefit (not to exceed 66 2/3 percent of monthly salary) without evidence of insurability. The pre-existing condition limitation applies to the full amount of coverage.

**Currently Insured Employees:** During the approved annual enrollment period, currently insured employees can increase their amount of coverage up to 66 2/3 percent of monthly salary without evidence of insurability. The pre-existing condition limitation applies to the increased amount of coverage including any reduction made to the elimination (waiting) period.

**Late Entrants:** During the approved annual enrollment period, active full-time employees can sign up for coverage and receive up to a $7,500 monthly benefit (not to exceed 66 2/3 percent of monthly salary) without evidence of insurability. The pre-existing condition limitation applies to the full amount of coverage.

***BENEFIT AMOUNT***

You may purchase a monthly benefit in $100 increments, starting at a minimum of $200, up to 66 2/3 percent of your monthly earnings to a maximum monthly benefit of $4,000 and in $500 increments thereafter up to a maximum monthly benefit of $7,500.

***ELIMINATION PERIOD (WAITING PERIOD)***

The Elimination Period is the length of time of continuous disability, due to sickness or injury, which must be satisfied before you are eligible to receive benefits. **You may choose an Elimination Period of 14, 30, 60 or 180 days.**

**Applies to Elimination Periods of 14 and 30 days ONLY--** If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement. Inpatient means that you are confined to a hospital room due to your sickness or injury for eight or more consecutive hours.

***DURATION OF BENEFITS***

The duration of benefits is based on your age when the disability occurs:

| Age at Disability | Maximum Benefit Period |
|---|---|
| Less than age 60 | SSNRA(Social Security Normal Retirement Age) |
| 60 | 60 months |
| 61 | 48 months |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 and over | 12 months |

***PROGRESSIVE INCOME BENEFIT***

If you have lost the ability to independently perform two of six Activities of Daily Living (ADLs) or suffered a deterioration or loss in intellectual capacity, you would be eligible to receive an additional 33 1/3% of your monthly earnings to a monthly maximum benefit of the lesser of the disability plan maximum monthly benefit or $5,000. The six ADLs are: bathing, dressing, toileting, transferring, continence, and eating.

You must be disabled for 12 months under the disability plan and be receiving monthly payments to be eligible for Progressive Income Benefits. Your Progressive Income Benefit will not be reduced by deductible sources of income.

***SURVIVOR BENEFIT***

Lincoln will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment. This benefit will be paid if, on the date of your death, your disability had continued for 180 or more consecutive days, and you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In that case, no payment will be made. However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

***PARTIAL DISABILITY: THE WORK INCENTIVE BENEFIT***

Because nobody wants to be out of work longer than absolutely necessary, Lincoln supports efforts that assist you to remain on the job or return to work as soon as possible. Lincoln will continue to send monthly payments to an employee with a disability who is working as described in the policy. *Refer to your policy regarding partial disability benefit calculations.*

***WAIVER OF PREMIUM***

After you have received disability payments under the plan you will not be required to pay premiums as long as you are receiving disability benefits.

***CONVERSION PRIVILEGE***

If your employment with OCPS ends, your coverage under the plan will end. However, you may be eligible to purchase insurance under Lincoln group conversion policy. To be eligible, you must have been insured under the plan for at least 12 consecutive months. Lincoln will determine the coverage you will have under the conversion policy. The conversion policy may not be the same coverage offered under your employer's group plan. Under certain circumstances, you may not convert your coverage. You must apply for conversion and pay the first quarterly premium within 31 days after the date your employment ends. *Some exclusions apply, see policy for details.*

***EMPLOYEE CONNECT EMPLOYEE ASSISTANCE PROGRAM*** [1]

Employee Connect is a comprehensive resource providing access to professional assistance for a wide range of personal and work-related issues. The service is available to you and your family members twenty-four hours a day, 365 days a year, and provides resources to help employees find solutions to everyday issues such as financing a car or selecting child care, as well as more serious problems such as alcohol or drug addiction, divorce, or relationship problems.

Services include: toll-free phone access to master's-level consultants, up to four face-to-face sessions to help with more serious issues; and online resources. There is no additional charge for utilizing the program. Participation is confidential and strictly voluntary, and employees do not have to have filed a disability claim or be receiving benefits to use the program.

***PREGNANCY BENEFIT***

Disability due to pregnancy or complications of pregnancy will be covered on the same basis as a sickness.

***PRE-EXISTING CONDITION EXCLUSION***

The plan will not cover any disability that begins in the first 12 months after your effective date of coverage that is caused by, contributed to by, or resulting from a pre-existing condition.

A pre-existing condition is a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three (3) months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

***DEFINITION OF DISABILITY***

Total Disability means that, due to an injury or sickness, an employee is unable:

1. During the ELIMINATION PERIOD and the "OWN OCCUPATION" Period, to perform each of the main duties of his or her regular occupation; and
2. After the "OWN OCCUPATION" Period, to perform each of the main duties of any occupation which his or her training, education or experience will reasonably allow.

The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

After 24 months, you are considered disabled when Lincoln determines that, due to the same sickness or injury, you are unable to perform the material and substantial duties of any occupation for which you are reasonably fitted by education, training or experience. You must be under the regular care of a doctor in order to be considered disabled.

***DEFINITION OF OWN OCCUPATION***

Own Occupation means the occupation, trade or profession:

1. in which the Insured Employee was employed with the Employer prior to Disability; and
2. which was his or her main source of earned income prior to Disability.

***RECURRENT DISABILITY***

If you have a recurring disability, under certain circumstances Lincoln may treat that disability as part of the prior claim, and you will not have to complete another elimination period (waiting period). *See policy for full details.*

***BENEFIT INTEGRATION***

The gross disability benefit will be reduced **immediately** by the following deductible sources of income:

The amount you receive or are entitled to receive from:

- a workers' compensation law;
- an occupational disease law;
- any other act or law with similar intent.

After you have received monthly disability payments for 12 months, your gross disability payment will be reduced by such items as additional deductible sources of income you receive or are entitled to receive under: state compulsory benefit laws; automobile liability insurance; legal judgments and settlements; certain retirement plans; salary continuation or sick leave plans; other group or association disability programs or insurance; and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs. *A full list of deductible sources is included in your policy, see policy for full details.*

***MENTAL ILLNESS LIMITATION***

Lincoln will pay benefits for disabilities due to a mental illness for up to 24 months. If you are confined to a hospital at the end of 24 months, benefits will continue during confinement.

***GENERAL EXCLUSIONS***

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from:

- intentionally self-inflicted injuries;
- active participation in a riot;
- commission of a crime for which you have been convicted;
- loss of professional license, occupational license or certification;
- pre-existing conditions (see definition).

Lincoln will not cover a disability due to war, declared or undeclared, or any act of war. Lincoln will not pay a benefit for any period of disability during which you are incarcerated.

***TERMINATION PROVISIONS***

Coverage under the summary of benefits or a plan ends on the earliest of:

- the date the group is cancelled;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the first day of any month for which continuous premium payments are not made;
- the end of the month in which employment ceases.*

*Ten-month employees who resign, retire or non-reappointed and have completed the school year will have coverage through the end of August.

***FEDERAL INCOME TAXATION***

The taxability of benefits depends on how premium was taxed during the plan year in which you become disabled. If you paid 100% of the premium for the plan year with post-tax dollars, your benefits will not be taxed. If you and your Employer share in the cost, then a portion of your benefits will be taxed.

This plan highlight is a summary provided to help you understand your insurance coverage from Lincoln. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern. For complete details of coverage, please refer to policy form number C.FP-1, et al.

[1] Work-life balance employee assistance program and On-Claim Support services are provided by Bensinger DuPont. Worldwide emergency travel assistance services are provided by Medex and are available with selected Lincoln insurance offerings. Exclusions, limitations and prior notice requirements may apply, and service features, terms and eligibility criteria are subject to change. The services are not valid after termination of coverage and may be withdrawn at any time. Please contact your Lincoln representative for full details.

# VI. DENTAL INSURANCE

**A. DELTACARE® USA BASIC MANAGED CARE DENTAL PLAN (PLAN FLM12)**

**B. DELTACARE® USA COMPREHENSIVE MANAGED CARE DENTAL PLAN (PLAN FLM97)**

**C. DELTA DENTAL PPO DENTAL PLAN (PREFERRED PROVIDER ORGANIZATION)**

**D. ORTHODONTICS DISCOUNT PROGRAM FOR EMPLOYEES**

**E. VISION DISCOUNT PROGRAM FOR EMPLOYEES**

# VI. DENTAL INSURANCE

## Overview

Under your dental coverage you may select **one** of three different options:

### A. DELTACARE® USA BASIC MANAGED CARE DENTAL PLAN

This is a plan designed for people who currently have healthy teeth and gums. This plan focuses on preventive dental maintenance, however, it also provides for other more complex dental work as well. You must use a participating general dentist to receive benefits.

### B. DELTACARE® USA COMPREHENSIVE MANAGED CARE PLAN

This plan offers a broader range of benefits including some restorative dental procedures (fillings) at no charge after a $5 office visit copayment. It offers a wide range of benefits for specialty referrals when you are referred by your participating general dentist.

Please Note: With either the **basic or comprehensive** managed care dental plans you receive the following benefits:

- No Deductibles
- No Claim Forms
- No Annual Maximum Benefit
- No Waiting Periods
- No Pre-Existing Condition Limitations

### C. DELTA DENTAL PPO (PREFERRED PROVIDER ORGANIZATION)

With this plan, you have the freedom to select any dentist you wish. If you choose to see a participating PPO dentist you will receive a higher level of payment for your dental work. You may decide at the time you receive services whether or not to use a participating provider.

### D. ORTHODONTICS DISCOUNT PROGRAM FOR EMPLOYEES

### E. VISION DISCOUNT PROGRAM FOR EMPLOYEES

DELTA DENTAL

Delta Dental Insurance Company

# ORANGE COUNTY PUBLIC SCHOOLS
# DENTAL PLAN OPTIONS

| Benefit Description | DeltaCare® USA Basic Plan FLM12* | DeltaCare® USA Comprehensive Plan FLM97* | Delta Dental In-PPO Network** | Delta Dental Out-Of-PPO Network** |
|---|---|---|---|---|
| | Employee Copayment | Employee Copayment | Delta Dental Pays | Delta Dental Pays |
| **Office Visit Copayment** | $5 per visit (1) | $5 per visit (1) | N/A | N/A |
| **DIAGNOSTIC** - oral examinations, x-rays | No Cost to $5 | No Cost to $5 | 100% | 80% |
| **PREVENTIVE** - routine cleanings (2 per 12-month period), fluoride treatment, sealants and space maintainers | No Cost to $90 | No Cost to $85 | 100% | 80% |
| **BASIC BENEFITS** - fillings, basic endodontics (root canal), basic periodontics, basic restoratives, denture repairs, oral surgery (incisions, excisions, surgical removal of tooth) | No Cost to $240 | No Cost to $300 | 80% | 60% |
| **MAJOR BENEFITS** - Crowns, inlays, onlays, cast restorations, bridges, dentures, major endodontics, major periodontics (gum treatment), major restoratives and major denture repairs | $15 to $355(2) | $12 to $375 | 50% | 40% |
| **ORTHODONTIC BENEFITS** - dependent children only | 75 percent of "filed fees" | $120 to $1,850 | N/A | N/A |
| **DEDUCTIBLE** | $0 | $0 | $25 per person<br>$75 per family per calendar year | $50 per person<br>$150 per family per calendar year |
| **PLAN YEAR MAXIMUM** | N/A | N/A | $1,300 per person per calendar year | $1,300 per person per calendar year |
| **LIFETIME MAXIMUM FOR ORTHODONTIC** | N/A | N/A | N/A | N/A |

*If you choose a DeltaCare® USA plan, you must use a DeltaCare® USA dentist for treatment. NOTE: If you choose the DeltaCare USA Basic Plan FLM12, when referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees."

**Delta Dental PPO® products offer freedom of choice of any dentist and you can maximize savings by utilizing PPO (in-network) dentists. Visiting a Delta Dental PPO provider usually saves patients almost 30% on average out-of-pocket costs.

**Delta Dental PPO plans includes the D&P Maximum Waiver benefit allowing you to obtain diagnostic and preventive dental services without those costs applying to the plan year maximum.

This is only a brief summary of the plans and reflects copayment ranges for the highly utilized procedures. The above procedures under DeltaCare® USA are subject to limitations and exclusions of the plan. The dental health plan contract must be consulted to determine the exact terms and conditions of coverage. A Certificate of Coverage will be sent to you upon enrollment.

(1) Includes office visit, per visit cost (in addition to other services).

--Under FLM97, there are no additional upgrade charges; the copayment reflects the Enrollee's total cost, including placement of porcelain/ceramic and other tooth colored material on molars, and lab costs.

# Your Choice — Prepaid or PPO

| Features | DeltaCare® USA plan (Prepaid) | Delta Dental PPO plan |
|---|---|---|
| **Dentist network** | • Visit your assigned DeltaCare® USA network dentist to receive benefits.<br>• Easy referrals to a large specialty care network (referred by selected primary care dentist). | • Freedom to choose any licensed dentist, anywhere in the world, each time you or a family member requires treatment<br>• No referral required for specialty care |
| **Selecting a dentist** | • Ability to change selected network dentist monthly with a phone call or email to Customer Service | • No need to preregister with a dental office.<br>• Ability to change dentists anytime without contacting Delta Dental |
| **Access** | • 16,000 facilities | • 166,000 dentist locations |
| **Deductible/Maximum** | • No annual deductible and no annual dollar maximum | • Annual deductible for all services except diagnostic and preventive<br>• An annual maximum |
| **Copayments/ Coinsurance** | • All covered procedures have predetermined copayments.<br>• No or minimal copayments for most diagnostic and preventive services.<br>• Minimal or no copayments for many restorative services. | • Covered services paid at applicable percentage of contract allowance (for example, 80%) |
| **Out-of-area coverage** | • Out-of-area (35 or more miles from selected network dentist) emergency care allowance, up to $100 per incident. | • Can visit any licensed dentist |
| **Covered Benefits** | • Wide range of covered services, including orthodontia<br>• Orthodontic takeover provision for new enrollees who have orthodontic treatment in progress (see plan booklet for full details) | • Wide range of covered services, including orthodontia |
| **Administration** | • No claim forms | • Claim forms filed by Delta Dental dentists |
| **Cost savings** | • Visit your selected DeltaCare® USA dentist to receive benefits.<br>• Pay only the copayment at the time of treatment. | • You usually have the lowest out-of-pocket expenses when visiting a Delta Dental PPO dentist.<br>• If you don’t see a PPO dentist, a Delta Dental Premier dentist is usually your next best option. |

**Delta Dental**
**Eligibility for Enrollment**

All of the Contract holder's retired employees and all permanent, present employees and regular part-time employees working 17.5 hours weekly who have completed 59 days of continuous employment will be eligible on the Effective Date.

All other permanent employees and regular part-time employees working 17.5 hours weekly will become effective on the first day of the month following 59 days of continuous employment.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:

- Lawful spouse;
- Same-sex domestic partner as defined by OCPS;
- Children from birth to the end of the calendar year in which occurs their 26th birthday if:
  (1) the child is dependent on the Eligible Person/Primary Enrollee for support; and

  (2) the child lives in the Enrollee's household; or

  (3) the child is a full-time or part-time student.

  Children includes natural children, step-children, children of a domestic partner, adopted children, foster children, custodial children and newborn children including a newborn child of a covered dependent child.

  Newborn children, including a newborn child of a covered dependent child or a newborn child where a written agreement to adopt has been entered into prior to birth, are eligible from the moment of birth. Adopted children, foster children and custodial children are eligible from the moment of placement in the Enrollee's residence. Notice of birth, adoption placement, foster home placement or other custodial placement of a child with Enrollee must be received within 31 days of the birth or placement. If notice of birth or adoption is received within the 31 day notice period, no additional premiums are due during the notice period. If notice is received within 60 days of the birth or adoption placement instead of 31 days, coverage will be effective from the date of birth or placement, but the Enrollee must pay any additional Premium from the date of birth or placement. Eligibility for a newborn child of covered dependent child terminates 18 months after the birth of the newborn.

• A child 26 years or older may continue to be eligible as a dependent if the child is not self-supporting because of physical handicap or mental incapacity that began before age 26 and the child is mostly dependent on the Eligible Employee for support and maintenance. Proof of incapacity will not be required until a claim has been denied due to a child having reached age 26. Proof of these facts must be given to Delta Dental or to the Contractholder within 31 days if it is requested. Proof will not be required more than once a year after the child is 27.

# VI. DENTAL INSURANCE

## A. DELTACARE® USA BASIC MANAGED CARE DENTAL PLAN (PLAN FLM12)

# DeltaCare® USA – provided by Delta Dental Insurance Company

We'll do **whatever it takes and then some.**

**Welcome to DeltaCare USA — quality, convenience, predictable costs**

DeltaCare USA is a dental program that provides you and your family with quality dental benefits at an affordable cost. Offered through Delta Dental Insurance Company, the DeltaCare USA program is designed to encourage you and your family to visit the dentist regularly to maintain your dental health.

When you enroll, you select a contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

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

Enroll in DeltaCare USA and you'll enjoy these features:

**Quality**

- Extensive benefits for you and your family
- No restrictions on pre-existing conditions, except for work in progress
- Large, stable network of dentists, so you can enjoy a long-term relationship with your dentist

**Convenience**

- No claim forms to complete
- Easy access to specialty care
- Expanded business hours for toll-free customer service, from 8 a.m. to 9 p.m., Eastern time

**Predictable costs**

- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to $100 per emergency
- No annual or lifetime dollar maximums

**Find a DeltaCare USA dentist**

Select from among the many conveniently located DeltaCare USA contracted general dentists. To find the most current listing of DeltaCare USA dental offices you can:

Visit our website at **deltadentalins.com/enrollees**. Under Find a dentist, select DeltaCare USA as your network.

Or call Customer Service at **800-422-4234** for help in finding a DeltaCare USA dentist.

DELTA DENTAL®

Administered by Delta Dental Insurance Company

## What if I have questions about my DeltaCare USA Program?

**Eligibility for you and your family**

If you meet your group's eligibility requirements for dental coverage, you can enroll in the DeltaCare USA program. You may also enroll eligible dependents. Contact your benefits administrator if you have any questions.

**Easy enrollment**

Simply complete the enrollment process as directed by your benefits administrator. Be sure to indicate a dentist (from the list of contract dental facilities) for both yourself and your eligible dependents. Include the name of your group.

**How your DeltaCare USA program works**

Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you.

After you have enrolled, you will receive a membership packet that includes an identification card and a Certificate of Coverage that fully describes the benefits of your dental program. Also included in this packet are the name, address and phone number of your contract dentist. Simply call the dental facility to make an appointment.

Under the DeltaCare USA program, many services are covered at no cost, while others have copayments (amount you pay your contract dentist) for certain benefits. See the "Description of Benefits and Copayments" for a list of your benefits.

Please note: Dental services that are not performed by your selected contract dentist, a contract specialist or are not covered under provisions for emergency care below, are not covered by your DeltaCare USA program.

**Provisions for emergency care**

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-area dental emergencies (35 or more miles from your contract dentist). Your program pays up to $100 for out-of-area emergency dental expenses per emergency for each enrollee.

**Accident injury benefit**

The DeltaCare USA program provides coverage for accidental injury (caused by external forces) at 100% of the contract dentist's "filed fees" for benefits (less any applicable copayments). The enrollee must be eligible under the DeltaCare USA program when the accident occurs. Accident injury benefits are subject to a $1600 maximum, per 12 months, per person.

**My dentist is a Delta Dental dentist but is not on the list of DeltaCare USA dentists. Can I still receive treatment from this dentist?**

You must receive treatment from your selected DeltaCare USA contract dentist. Please note that Delta Dental dentists are not necessarily DeltaCare USA dentists.

**Do my family members receive treatment from the same DeltaCare USA contract dentist?**

You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three contract dental facilities.

**Can I change my contract dentist?**

You may change contract dentists by notifying us either by phone or in writing, or by visiting our website (deltadentalins.com). If you contact us by the 21st of the month, the change will become effective the first of the following month.

## Highlights of your DeltaCare USA Program

**Can I have my teeth whitened under the DeltaCare USA program?**

External bleaching is a benefit under your program, subject to certain limitations. Talk to your contract dentist about your options.

**Does my DeltaCare USA program cover tooth-colored fillings and crowns on molars?**

The upgrade to porcelain and other tooth-colored materials on molars is included as a benefit under your program. The copayment shows you what your out of pocket cost will be.

**How long does it take to get an appointment with a DeltaCare USA dentist?**

Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer. Most DeltaCare USA dentists are in private group practices, which means greater appointment availability and extended office hours.

**Are pre-existing dental conditions and work in progress covered?**

Treatment for pre-existing conditions, such as extracted teeth, is covered under the DeltaCare USA program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures). Orthodontic treatment in progress may be covered for new DeltaCare USA enrollees. See the "Limitations and Exclusions of Benefits."

**How does the DeltaCare USA program encourage preventive care?**

Your DeltaCare USA program is designed to encourage regular visits to the dentist by having no copayments (fees you pay to the contract dentist) on most diagnostic and preventive benefits. See the enclosed "Description of Benefits and Copayments."

**Does my DeltaCare USA program cover specialists' services?**

Should you need a specialist (endodontist, orthodontist, oral surgeon, periodontist or pediatric dentist), you may be referred by your participating contract dentist, or you may refer yourself to any participating contract specialist from our directory. Upon identifying yourself as a DeltaCare USA enrollee, you will receive a 25% reduction from the participating contract specialist's "filed fees" for covered services performed. Specialist services are available only in areas where DeltaCare USA has participating contract specialist.

**What if I have questions about my DeltaCare USA program?**

Call Customer Service at 800-422-4234. We have multilingual representatives available from 8 a.m. to 9 p.m. Eastern time, Monday through Friday. Our Customer Service representatives can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

**Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.**

**SCHEDULE A**

**Description of Benefits and Copayments**

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

**Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2015 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.**

| CODE | DESCRIPTION | ENROLLEE PAYS |
|---|---|---|
| **D0100-D0999** | **I. DIAGNOSTIC - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **** | |
| D0120 | Periodic oral evaluation - established patient | No Cost |
| D0140 | Limited oral evaluation - problem focused | No Cost |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | No Cost |
| D0150 | Comprehensive oral evaluation - new or established patient | No Cost |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | No Cost |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | No Cost |
| D0171 | Re-evaluation - post-operative office visit | $5.00 |
| D0180 | Comprehensive periodontal evaluation - new or established patient | No Cost |
| D0190 | Screening of a patient | No Cost |
| D0191 | Assessment of a patient | No Cost |
| D0210 | Intraoral - complete series of radiographic images - *limited to 1 series every 24 months* | No Cost |
| D0220 | Intraoral - periapical first radiographic image | No Cost |
| D0230 | Intraoral - periapical each additional radiographic image | No Cost |
| D0240 | Intraoral - occlusal radiographic image | No Cost |
| D0270 | Bitewing - single radiographic image | No Cost |
| D0272 | Bitewings - two radiographic images | No Cost |
| D0273 | Bitewings three radiographic images | No Cost |
| D0274 | Bitewings - four radiographic images - *limited to 1 series every 6 months* | No Cost |
| D0330 | Panoramic radiographic image | No Cost |
| D0460 | Pulp vitality tests | No Cost |
| D0470 | Diagnostic casts | No Cost |
| D0601 | Caries risk assessment and documentation, with a finding of low risk - *limited to children age 3 to 19, 1 every 3 years* | No Cost |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk - *limited to children age 3 to 19, 1 every 3 years* | No Cost |
| D0603 | Caries risk assessment and documentation, with a finding of high risk - *limited to children age 3 to 19, 1 every 3 years* | No Cost |
| D0999 | Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)* | $5.00 |
| **D1000-D1999** | **II. PREVENTIVE - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **** | |
| D1110 | Prophylaxis *cleaning* - adult - *1 per 6 month period* | No Cost |
| D1110 | *Additional prophylaxis cleaning - adult (within the 6 month period)* | $20.00 |
| D1120 | Prophylaxis *cleaning* - child - *1 per 6 month period* | No Cost |
| D1120 | *Additional prophylaxis cleaning - child (within the 6 month period)* | $20.00 |
| D1206 | Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period* | No Cost |
| D1208 | Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period* | No Cost |
| D1330 | Oral hygiene instructions | No Cost |
| D1351 | Sealant - per tooth - *limited to permanent molars through age 15* | $10.00 |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15* | $10.00 |
| D1353 | Sealant repair - per tooth - *limited to permanent molars through age 15* | $10.00 |
| D1510 | Space maintainer - fixed - unilateral | $50.00 |
| D1515 | Space maintainer - fixed - bilateral | $50.00 |

| | | |
|---|---|---|
| D1520 | Space maintainer - removable - unilateral | $90.00 |
| D1525 | Space maintainer - removable - bilateral | $90.00 |

**D2000-D2999 III. RESTORATIVE -** ***When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

*- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*

| | | |
|---|---|---|
| D2140 | Amalgam - one surface, primary or permanent | $15.00 |
| D2150 | Amalgam - two surfaces, primary or permanent | $25.00 |
| D2160 | Amalgam - three surfaces, primary or permanent | $35.00 |
| D2161 | Amalgam - four or more surfaces, primary or permanent | $45.00 |
| D2330 | Resin-based composite - one surface, anterior | $50.00 |
| D2331 | Resin-based composite - two surfaces, anterior | $57.00 |
| D2332 | Resin-based composite - three surfaces, anterior | $63.00 |
| D2391 | Resin-based composite - one surface, posterior | $75.00 |
| D2392 | Resin-based composite - two surfaces, posterior | $80.00 |
| D2393 | Resin-based composite - three surfaces, posterior | $85.00 |
| D2394 | Resin-based composite - four or more surfaces, posterior | $95.00 |
| D2510 | Inlay - metallic - one surface [2, 8] | $115.00 |
| D2520 | Inlay - metallic - two surfaces [2, 8] | $140.00 |
| D2530 | Inlay - metallic - three or more surfaces [2, 8] | $150.00 |
| D2542 | Onlay - metallic - two surfaces [2, 8] | $150.00 |
| D2543 | Onlay - metallic - three surfaces [2, 8] | $160.00 |
| D2544 | Onlay - metallic - four or more surfaces [2, 8] | $170.00 |
| D2710 | Crown - resin-based composite (indirect) [1, 2] | $170.00 |
| D2712 | Crown - ¾ resin-based composite (indirect) [1, 2] | $170.00 |
| D2720 | Crown - resin with high noble metal [1, 2] | $355.00 |
| D2721 | Crown - resin with predominantly base metal [1, 2] | $255.00 |
| D2722 | Crown - resin with noble metal [1, 2] | $255.00 |
| D2740 | Crown - porcelain/ceramic substrate [1, 2] | $355.00 |
| D2750 | Crown - porcelain fused to high noble metal [1, 2] | $355.00 |
| D2751 | Crown - porcelain fused to predominantly base metal [1, 2] | $255.00 |
| D2752 | Crown - porcelain fused to noble metal [1, 2] | $255.00 |
| D2780 | Crown - ¾ cast high noble metal [2] | $330.00 |
| D2781 | Crown - ¾ cast predominantly base metal [2] | $230.00 |
| D2782 | Crown - ¾ cast noble metal [2] | $230.00 |
| D2790 | Crown - full cast high noble metal [2] | $330.00 |
| D2791 | Crown - full cast predominantly base metal [2] | $230.00 |
| D2792 | Crown - full cast noble metal [2] | $230.00 |
| D2794 | Crown - titanium [2] | $355.00 |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | $15.00 |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | $15.00 |
| D2920 | Re-cement or re-bond crown | $15.00 |
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth - *anterior* | $55.00 |
| D2930 | Prefabricated stainless steel crown - primary tooth | $55.00 |
| D2931 | Prefabricated stainless steel crown - permanent tooth | $55.00 |
| D2932 | Prefabricated resin crown - *anterior primary tooth* | $65.00 |
| D2933 | Prefabricated stainless steel crown with resin window - *anterior primary tooth* | $55.00 |
| D2940 | Protective restoration | No Cost |
| D2941 | Interim therapeutic restoration - primary dentition | No Cost |
| D2951 | Pin retention - per tooth, in addition to restoration | $20.00 |
| D2952 | Post and core in addition to crown, indirectly fabricated - *includes canal preparation* [8] | $80.00 |
| D2953 | Each additional indirectly fabricated post - same tooth - *includes canal preparation* [8] | $35.00 |
| D2954 | Prefabricated post and core in addition to crown - *base metal post; includes canal preparation* | $80.00 |
| D2957 | Each additional prefabricated post - same tooth - *base metal post; includes canal preparation* | $25.00 |
| D2960 | Labial veneer (resin laminate) - chairside | $100.00 |
| D2961 | Labial veneer (resin laminate) - laboratory | $155.00 |

| | | |
|---|---|---|
| D2962 | Labial veneer (porcelain laminate) - laboratory | $345.00 |
| D2970 | Temporary crown (fractured tooth) - *palliative treatment only* | $20.00 |
| D2980 | Crown repair necessitated by restorative material failure | $20.00 |
| D2981 | Inlay repair necessitated by restorative material failure | $20.00 |
| D2982 | Onlay repair necessitated by restorative material failure | $20.00 |
| D2983 | Veneer repair necessitated by restorative material failure | $20.00 |
| D2990 | Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15* | $10.00 |

**D3000-D3999 IV. ENDODONTICS - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

| | | |
|---|---|---|
| D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | $25.00 |
| D3221 | Pulpal debridement, primary and permanent teeth | $34.00 |
| D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | $25.00 |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | $34.00 |
| D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | $34.00 |
| D3310 | *Root canal* - endodontic therapy, anterior tooth (excluding final restoration) [9] | $125.00 |
| D3320 | *Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration) [9] | $195.00 |
| D3330 | *Root canal* - endodontic therapy, molar (excluding final restoration) [9] | $240.00 |
| D3410 | Apicoectomy - anterior [9] | $95.00 |
| D3421 | Apicoectomy - bicuspid (first root) [9] | $95.00 |
| D3425 | Apicoectomy - molar (first root) [9] | $95.00 |
| D3426 | Apicoectomy (each additional root) [9] | $60.00 |
| D3427 | Periradicular surgery without apicoectomy | $95.00 |
| D3430 | Retrograde filling - per root [9] | $60.00 |
| D3450 | Root amputation, per root - *not covered in conjunction with a hemisection* [9] | $70.00 |

**D4000-D4999 V. PERIODONTICS - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

*- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

| | | |
|---|---|---|
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | $110.00 |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | $25.00 |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | $25.00 |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | $210.00 |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | $210.00 |
| D4277 | Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft | $210.00 |
| D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site | $210.00 |
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* | $55.00 |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* | $55.00 |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months* | $50.00 |
| D4910 | Periodontal maintenance - *limited to 1 treatment each 6 month period* | $45.00 |
| D4921 | Gingival irrigation - per quadrant | No Cost |

**D5000-D5899 VI. PROSTHODONTICS (removable)**

| | | |
|---|---|---|
| D5110 | Complete denture - maxillary [3, 10] | $260.00 |
| D5120 | Complete denture - mandibular [3, 10] | $260.00 |
| D5130 | Immediate denture - maxillary [3, 10] | $280.00 |
| D5140 | Immediate denture - mandibular [3, 10] | $280.00 |
| D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [3, 10] | $275.00 |
| D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [3, 10] | $275.00 |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [3, 10] | $315.00 |

| | | |
|---|---|---|
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [3, 10] | $315.00 |
| D5410 | Adjust complete denture - maxillary [3] | $15.00 |
| D5411 | Adjust complete denture - mandibular [3] | $15.00 |
| D5421 | Adjust partial denture - maxillary [3] | $15.00 |
| D5422 | Adjust partial denture - mandibular [3] | $15.00 |
| D5510 | Repair broken complete denture base | $15+lab |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | $15+lab |
| | *Additional* | $10+lab |
| D5610 | Repair resin denture base | $15+lab |
| D5620 | Repair cast framework | $15+lab |
| D5630 | Repair or replace broken clasp | $15+lab |
| D5640 | Replace broken teeth - per tooth | $15+lab |
| D5650 | Add tooth to existing partial denture | $30.00 |
| D5660 | Add clasp to existing partial denture | $30+lab |
| D5730 | Reline complete maxillary denture (chairside) [11] | $45.00 |
| D5731 | Reline complete mandibular denture (chairside) [11] | $45.00 |
| D5740 | Reline maxillary partial denture (chairside) [11] | $45.00 |
| D5741 | Reline mandibular partial denture (chairside) [11] | $45.00 |
| D5750 | Reline complete maxillary denture (laboratory) [11] | $35+lab |
| D5751 | Reline complete mandibular denture (laboratory) [11] | $35+lab |
| D5760 | Reline maxillary partial denture (laboratory) [11] | $35+lab |
| D5761 | Reline mandibular partial denture (laboratory) [11] | $35+lab |
| D5850 | Tissue conditioning, maxillary [3, 11] | $25.00 |
| D5851 | Tissue conditioning, mandibular [3, 11] | $25.00 |

**D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered**

**D6000-D6199 VIII. IMPLANT SERVICES - Not Covered**

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

| | | |
|---|---|---|
| D6210 | Pontic - cast high noble metal [4] | $330.00 |
| D6211 | Pontic - cast predominantly base metal [4] | $230.00 |
| D6212 | Pontic - cast noble metal [4] | $230.00 |
| D6240 | Pontic - porcelain fused to high noble metal [1, 4] | $355.00 |
| D6241 | Pontic - porcelain fused to predominantly base metal [1, 4] | $255.00 |
| D6242 | Pontic - porcelain fused to noble metal [1, 4] | $255.00 |
| D6245 | Pontic - porcelain/ceramic [1, 4] | $355.00 |
| D6250 | Pontic - resin with high noble metal [1, 4] | $355.00 |
| D6251 | Pontic - resin with predominantly base metal [1, 4] | $255.00 |
| D6252 | Pontic - resin with noble metal [1, 4] | $255.00 |
| D6720 | Crown - resin with high noble metal [1, 4] | $355.00 |
| D6721 | Crown - resin with predominantly base metal [1, 4] | $255.00 |
| D6722 | Crown - resin with noble metal [1, 4] | $255.00 |
| D6740 | Crown - porcelain/ceramic [1, 4] | $355.00 |
| D6750 | Crown - porcelain fused to high noble metal [1, 4] | $355.00 |
| D6751 | Crown - porcelain fused to predominantly base metal [1, 4] | $255.00 |
| D6752 | Crown - porcelain fused to noble metal [1, 4] | $255.00 |
| D6780 | Crown - ¾ cast high noble metal [4] | $330.00 |
| D6781 | Crown - ¾ cast predominantly base metal [4] | $230.00 |
| D6782 | Crown - ¾ cast noble metal [4] | $230.00 |
| D6790 | Crown - full cast high noble metal [4] | $330.00 |
| D6791 | Crown - full cast predominantly base metal [4] | $230.00 |
| D6792 | Crown - full cast noble metal [4] | $230.00 |
| D6930 | Re-cement or re-bond fixed partial denture | $20.00 |

| | | |
|---|---|---|
| D6940 | Stress breaker [4] | $35.00 |
| D6980 | Fixed partial denture repair necessitated by restorative material failure | $30.00 |

**D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

*- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

| | | |
|---|---|---|
| D7111 | Extraction, coronal remnants - deciduous tooth | $15.00 |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | $15.00 |
| D7210 | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | $35.00 |
| D7220 | Removal of impacted tooth - soft tissue | $55.00 |
| D7230 | Removal of impacted tooth - partially bony | $75.00 |
| D7240 | Removal of impacted tooth - completely bony | $95.00 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | $95.00 |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | $33.00 |
| D7251 | Coronectomy - intentional partial tooth removal | $95.00 |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | $15.00 |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | $15.00 |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | $45.00 |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | $45.00 |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | $45.00 |
| D7461 | Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm | $40.00 |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | $28.00 |
| D7960 | Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure | $45.00 |
| D7970 | Excision of hyperplastic tissue - per arch | $50.00 |

**D8000-D8999 XI. ORTHODONTICS**

** *If a Copayment dollar amount is not listed, Enrollee pays 75 percent of the Contract Orthodontist's "filed fees."*

| | | |
|---|---|---|
| D8070 | Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* [7] | ** |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* [7] | ** |
| D8090 | Comprehensive orthodontic treatment of the adult dentition - *adults, including dependent adult children covered as full-time students* [7] | ** |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development - *not to be charged with any other consultation procedure(s)* [5] | No Cost |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) [6] | ** |

**D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES - *When referable services are provided by a Contract Specialist, the Enrollee pays 75 percent of that Dentist's "filed fees." **

| | | |
|---|---|---|
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | $20.00 |
| D9211 | Regional block anesthesia | No Cost |
| D9212 | Trigeminal division block anesthesia | No Cost |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | No Cost |
| D9219 | Evaluation for deep sedation or general anesthesia | No Cost |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | $5.00 |
| D9440 | Office visit - after regularly scheduled hours | $35.00 |
| D9931 | Cleaning and inspection of a removable appliance | No Cost |
| D9951 | Occlusal adjustment, limited | $25.00 |
| D9952 | Occlusal adjustment, complete | $150.00 |
| D9986 | Missed appointment - *without 24 hour notice - per 15 minutes of appointment time* | $10.00 |
| D9987 | Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time* | $10.00 |

All procedures listed may not be performed by the participating Contract Dentist selected by the Enrollee. The copayments shown apply to those DeltaCare USA participating Contract Dentists who perform those services and are not applicable for services performed by a participating Contract Specialist. Therefore, the Enrollee is encouraged to discuss availability of the scheduled services with their participating Contract Dentist. Procedures not listed that are performed by the participating Contract Dentist will be charged at the participating Contract Dentist's "filed fees" less 25%. Coverage for second opinions requested by the enrollee to determine the appropriateness of a treatment plan are covered at no cost to the enrollee.

* Should the Enrollee need a specialist (endodontist, orthodontist, oral surgeon, periodontist or pediatric dentist), they may be referred by their participating Contract Dentist, or they may refer themselves to any participating Contract Specialist from our directory. Upon

identification as a DeltaCare USA Enrollee, they will receive a 25% reduction from the participating Contract Specialist's "filed fees" for covered services performed. Specialist services are available only in areas where Delta Dental has a participating Contract Specialist.

"Filed fees" means the Contract Dentist's or Contract Specialist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

FOOTNOTES

1 *Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $150.00.*

2 *Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.*

3 *Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.*

4 *Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.*

5 *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, the Enrollee will receive a 25% reduction from the participating Contract Orthodontist's "filed fee." The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*

6 *Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of $75.00 applies.*

7 *Listed Copayment covers up to 24 months of active orthodontic treatment. Beyond 24 months of active treatment, an additional monthly fee of $75.00 applies.*

8 *Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional maximum cost to the Enrollee of $100.00 per tooth. If an indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade.*

9 *A Benefit for permanent teeth only.*

10 *Replacement is subject to a limitation requiring the existing denture to be 5+ years old.*

11 *Limited to 1 per denture during any 12 consecutive months.*

**SCHEDULE B**

**Limitations of Benefits**

1. Full mouth x-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to not more than one series of four films in any six month period.
3. Diagnostic casts are limited to aid in diagnosis by the Contract Dentist for covered benefits.
4. Prophylaxis or periodontal maintenance is limited to one procedure each six month period at no cost. There is a $20.00 Copayment for additional prophylaxis within the six month period.
5. Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15. Benefits for sealants do not include the repair or replacement of a sealant on any tooth within three years of its application.
6. A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
7. A crown is a benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five year limitation (Limitation #11).
8. A covered metallic inlay, onlay or indirectly fabricated post and core using base or noble metal is available for listed Copayment(s). If the Enrollee elects to have high noble metal used instead, the maximum additional cost of this material upgrade is $100.00 per tooth or pontic.
9. For molars, a covered inlay, onlay, crown, or unit of a fixed partial denture (bridge) is metallic without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $150.00 per molar.
10. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
11. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
    a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
    b. Either of the following:
        - The existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**
        - If an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
12. With the exception of pulpotomies, endodontic procedures (e.g. root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth.
13. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.
14. Periodontal scaling and root planing are limited to four quadrants during any 12 month period.
15. Full mouth debridement (gross scale) is limited to one treatment in any 12 month period.
16. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture:
    a. Fixed partial denture (bridge):
        - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**
        - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics (see Limitation #11); **or**
        - Each abutment tooth to be crowned meets Limitation #7.
    b. Removable partial denture:
        - Cast metal (D5213, D5214), one or more teeth are missing in an arch.
        - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease (see Limitation #11).
17. Relines and tissue conditioning are limited to one per denture during any 12 consecutive months.
18. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:

- The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**
- The replacement of permanent tooth/teeth for children under 16 years of age.

19. Retained primary teeth shall be covered as primary teeth.

20. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.

21. In cases of accidental injury, benefits available are described in *Schedule B, Accident Injury Benefit*. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in *Schedules A, Description of Benefits and Copayments; and B, Limitations and Exclusions of Benefits.*

22. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on Schedule A. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.

23. A new removable partial, complete or immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.

24. Procedures not listed on the schedule of benefits and copayments are excluded; however, if performed by the participating Contract Dentist, the Enrollee will be charged the participating Contract Dentist's "filed fee" less 25%.

"Filed fees" mean the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

**Exclusions of Benefits**

1. Any service provided by an oral surgeon, endodontist, periodontist, orthodontist or pediatric dentist that is not specifically listed as a covered procedure.

2. Dental conditions arising out of and due to Enrollee's employment for which Worker's Compensation is paid. Services that are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.

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

4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).

5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

6. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics.

7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.), except for the treatment of newborn children with congenital defects or birth abnormalities.

8. Dispensing of drugs not normally supplied in a dental facility.

9. Any procedure that in the professional opinion of the Contract Dentist or Delta Dental's dental consultant:

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

   b. is inconsistent with generally accepted standards for dentistry.

10. Dental services received from any dental facility other than the assigned Contract Dentist, participating Contract Specialist or as cited under *Emergency Services*.

11. Consultations for non-covered benefits.

12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

13. Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth except as shown on the schedule of benefits and copayments.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) except as shown on the schedule of benefits and copayments.

16. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare USA program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the benefit for other covered services.

17. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.

19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.

20. Treatment required by reason of war, declared or undeclared.

**Orthodontic Limitations**

The DeltaCare USA program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed in *Schedule A, Description of Benefits and Copayments* and subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.

2. Benefits cover 24 months of active comprehensive orthodontic treatment. Included is the initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustment to retainers and office visits for a maximum of two years.

3. Treatment plans extending beyond 24 months of active treatment, or 24 months of the retention phase of treatment will be subject to a monthly office visit fee to the Enrollee not to exceed $75.00 per month.

4. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of any balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of 100% of the participating Contract Dentist's orthodontic "filed fee" for covered adults and dependent children to age 25. The amount will be prorated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist.

5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will receive a 25% reduction from "filed fees" in addition to the total cost of diagnostic record fees.

6. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist's usual fee.

7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

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

"Filed fees" means the Contract Orthodontist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

**Orthodontic Exclusions**

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.

2. Lost, stolen or broken orthodontic appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind, and/or lack of Enrollee cooperation.
5. Surgical procedures incidental to orthodontic treatment.
6. Myofunctional therapy.
7. Surgical procedures related to cleft palate, micrognathia or macrognathia.
8. Treatment related to temporomandibular joint disturbances.
9. Supplemental appliances not routinely used in typical comprehensive orthodontics.
10. Restorative work caused by orthodontic treatment.
11. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
12. Extractions solely for the purpose of orthodontics.
13. Treatment in progress at inception of eligibility.
14. Transfer after banding has been initiated.
15. Composite bands, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

**Accident Injury Benefit**

An accidental injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A, Description of Benefits and Copayments*.

Delta Dental will pay up to 100% of the Contract Dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a Maximum of $1,600.00 in any 12 month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*.

CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits is subject to *Schedule B, Limitations and Exclusions of Benefits*, in addition to the following provisions:

MAXIMUM

Accident injury benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

LIMITATION

Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.

EXCLUSIONS

In addition to *Schedule B*, limitations #13, #18, #19, #21 and #24 and exclusions #2-9, #11-15 and #18-20, the following exclusions apply:

1. Prophylaxis.
2. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
3. Replacement of existing restorations due to decay.

4. Orthodontic services (treatment of malalignment of teeth and/or jaws).

5. Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

"Filed fees" mean the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

**SmileWay® Wellness Program**

Find all of our dental health resources, including a risk assessment tool, articles, videos and a free e-newsletter subscription, at: **mysmileway.com**.

**DeltaCare USA Customer Service**

800-422-4234

**NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN.**

The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. A Certificate of Coverage will be sent to you upon enrollment. **If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.**

*In Florida, DeltaCare USA is underwritten and administered by Delta Dental Insurance Company.*

**Customer Service**
800-422-4234
Monday through Friday
8 a.m. to 9 p.m., Eastern time

*Provided by:*
**Delta Dental Insurance Company**
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

DELTA DENTAL®

**deltadentalins.com/enrollees**

# VI. DENTAL INSURANCE

## B. DELTACARE® USA COMPREHENSIVE MANAGED CARE DENTAL PLAN (PLAN FLM97)

# DeltaCare® USA – provided by Delta Dental Insurance Company

We'll do **whatever it takes and then some.**

**Welcome to DeltaCare USA — quality, convenience, predictable costs**

DeltaCare USA is a dental program that provides you and your family with quality dental benefits at an affordable cost. Offered through Delta Dental Insurance Company, the DeltaCare USA program is designed to encourage you and your family to visit the dentist regularly to maintain your dental health.

When you enroll, you select a contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

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

Enroll in DeltaCare USA and you'll enjoy these features:

**Quality**

- Extensive benefits for you and your family
- No restrictions on pre-existing conditions, except for work in progress
- Large, stable network of dentists, so you can enjoy a long-term relationship with your dentist

**Convenience**

- No claim forms to complete
- Easy access to specialty care
- Expanded business hours for toll-free customer service, from 8 a.m. to 9 p.m., Eastern time

**Predictable costs**

- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to $100 per emergency
- No annual or lifetime dollar maximums

**Find a DeltaCare USA dentist**

Select from among the many conveniently located DeltaCare USA contracted general dentists. To find the most current listing of DeltaCare USA dental offices you can:

Visit our website at **deltadentalins.com/enrollees**. Under Find a dentist, select DeltaCare USA as your network.

Or call Customer Service at **800-422-4234** for help in finding a DeltaCare USA dentist.

DELTA DENTAL®

Administered by Delta Dental Insurance Company

## What if I have questions about my DeltaCare USA Program?

**Eligibility for you and your family**

If you meet your group's eligibility requirements for dental coverage, you can enroll in the DeltaCare USA program. You may also enroll eligible dependents. Contact your benefits administrator if you have any questions.

**Easy enrollment**

Simply complete the enrollment process as directed by your benefits administrator. Be sure to indicate a dentist (from the list of contract dental facilities) for both yourself and your eligible dependents. Include the name of your group.

**How your DeltaCare USA program works**

Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you.

After you have enrolled, you will receive a membership packet that includes an identification card and a Certificate of Coverage that fully describes the benefits of your dental program. Also included in this packet are the name, address and phone number of your contract dentist. Simply call the dental facility to make an appointment.

Under the DeltaCare USA program, many services are covered at no cost, while others have copayments (amount you pay your contract dentist) for certain benefits. See the "Description of Benefits and Copayments" for a list of your benefits.

Please note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care below, must be preauthorized by us to be covered by your DeltaCare USA program.

**Provisions for emergency care**

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-area dental emergencies (35 or more miles from your contract dentist). Your program pays up to $100 for out-of-area emergency dental expenses per emergency for each enrollee.

**Accident injury benefit**

The DeltaCare USA program provides coverage for accidental injury (caused by external forces) at 100% of the contract dentist's "filed fees" for benefits (less any applicable copayments). The enrollee must be eligible under the DeltaCare USA program when the accident occurs. Accident injury benefits are subject to a $1600 maximum, per 12 months, per person.

**My dentist is a Delta Dental dentist but is not on the list of DeltaCare USA dentists. Can I still receive treatment from this dentist?**

You must receive treatment from your selected DeltaCare USA contract dentist. Please note that Delta Dental dentists are not necessarily DeltaCare USA dentists.

**Do my family members receive treatment from the same DeltaCare USA contract dentist?**

You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three contract dental facilities.

**Can I change my contract dentist?**

You may change contract dentists by notifying us either by phone or in writing, or by visiting our website (deltadentalins.com). If you contact us by the 21st of the month, the change will become effective the first of the following month.

## Highlights of your DeltaCare USA Program

**Can I have my teeth whitened under the DeltaCare USA program?**

External bleaching is a benefit under your program, subject to certain limitations. Talk to your contract dentist about your options.

**Does my DeltaCare USA program cover tooth-colored fillings and crowns on molars?**

The upgrade to porcelain and other tooth-colored materials on molars is included as a benefit under your program. The copayment shows you what your out of pocket cost will be.

**How long does it take to get an appointment with a DeltaCare USA dentist?**

Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer. Most DeltaCare USA dentists are in private group practices, which means greater appointment availability and extended office hours.

**Are pre-existing dental conditions and work in progress covered?**

Treatment for pre-existing conditions, such as extracted teeth, is covered under the DeltaCare USA program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures). Orthodontic treatment in progress may be covered for new DeltaCare USA enrollees. See the "Limitations and Exclusions of Benefits."

**How does the DeltaCare USA program encourage preventive care?**

Your DeltaCare USA program is designed to encourage regular visits to the dentist by having no copayments (fees you pay to the contract dentist) on most diagnostic and preventive benefits. See the enclosed "Description of Benefits and Copayments."

**Does my DeltaCare USA program cover specialists' services?**

Your contract dentist will coordinate your specialty care needs for oral surgery, endodontics, periodontics or pediatric dentistry with an approved contract specialist. Specialist services are available only in areas where DeltaCare USA has participating contract specialists. Benefits for procedures not listed on the description of benefits that are performed by a participating contract specialist are available at the participating contract specialist's 'filed fees' less 25%.

**What if I have questions about my DeltaCare USA program?**

Call Customer Service at 800-422-4234. We have multilingual representatives available from 8 a.m. to 9 p.m. Eastern time, Monday through Friday. Our Customer Service representatives can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

**Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.**

**SCHEDULE A**

**Description of Benefits and Copayments**

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

**Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and is not to be interpreted as CDT-2015 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.**

| CODE | DESCRIPTION | ENROLLEE PAYS |
|---|---|---|
| **D0100-D0999** | **I. DIAGNOSTIC - (*When services are provided by a Contract Specialist, the Enrollee pays the copayment noted*) *** | |
| D0120 | Periodic oral evaluation - established patient | No Cost |
| D0140 | Limited oral evaluation - problem focused | No Cost |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | No Cost |
| D0150 | Comprehensive oral evaluation - new or established patient | No Cost |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | No Cost |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | No Cost |
| D0171 | Re-evaluation - post-operative office visit | $5.00 |
| D0180 | Comprehensive periodontal evaluation - new or established patient | No Cost |
| D0190 | Screening of a patient | No Cost |
| D0191 | Assessment of a patient | No Cost |
| D0210 | Intraoral - complete series of radiographic images - *limited to 1 series every 24 months* | No Cost |
| D0220 | Intraoral - periapical first radiographic image | No Cost |
| D0230 | Intraoral - periapical each additional radiographic image | No Cost |
| D0240 | Intraoral - occlusal radiographic image | No Cost |
| D0270 | Bitewing - single radiographic image | No Cost |
| D0272 | Bitewings - two radiographic images | No Cost |
| D0273 | Bitewings three radiographic images | No Cost |
| D0274 | Bitewings - four radiographic images - *limited to 1 series every 6 months* | No Cost |
| D0277 | Vertical bitewings - 7 to 8 radiographic images | No Cost |
| D0330 | Panoramic radiographic image | No Cost |
| D0415 | Collection of microorganisms for culture and sensitivity | No Cost |
| D0425 | Caries susceptibility tests | No Cost |
| D0460 | Pulp vitality tests | No Cost |
| D0470 | Diagnostic casts | No Cost |
| D0601 | Caries risk assessment and documentation, with a finding of low risk - *limited to children age 3 to 19, 1 every 3 years* | No Cost |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk - *limited to children age 3 to 19, 1 every 3 years* | No Cost |
| D0603 | Caries risk assessment and documentation, with a finding of high risk - *limited to children age 3 to 19, 1 every 3 years* | No Cost |
| D0999 | Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)* | $5.00 |
| **D1000-D1999** | **II. PREVENTIVE - (*When services are provided by a Contract Specialist, the Enrollee pays the copayment noted*) *** | |
| D1110 | Prophylaxis *cleaning* - adult - *1 per 6 month period* | No Cost |
| D1110 | *Additional prophylaxis cleaning - adult (within the 6 month period)* | $15.00 |
| D1120 | Prophylaxis *cleaning* - child - *1 per 6 month period* | No Cost |
| D1120 | *Additional prophylaxis cleaning - child (within the 6 month period)* | $15.00 |
| D1206 | Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period* | No Cost |
| D1208 | Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period* | No Cost |
| D1310 | Nutritional counseling for control of dental disease | No Cost |
| D1330 | Oral hygiene instructions | No Cost |
| D1351 | Sealant - per tooth - *limited to permanent molars through age 15* | $7.00 |

| | | |
|---|---|---|
| D1352 | Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15* | $7.00 |
| D1353 | Sealant repair - per tooth - *limited to permanent molars through age 15* | $7.00 |
| D1510 | Space maintainer - fixed - unilateral | $45.00 |
| D1515 | Space maintainer - fixed - bilateral | $45.00 |
| D1520 | Space maintainer - removable - unilateral | $85.00 |
| D1525 | Space maintainer - removable - bilateral | $85.00 |
| D1550 | Re-cement or re-bond space maintainer | $10.00 |
| D1555 | Removal of fixed space maintainer | $10.00 |

**D2000-D2999 III. RESTORATIVE - (*When services are provided by a Contract Specialist, the Enrollee pays the copayment noted*) ***

*- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*
*- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $125.00 per crown, beyond the 6th unit.*
*- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.*

| | | |
|---|---|---|
| D2140 | Amalgam - one surface, primary or permanent | No Cost |
| D2150 | Amalgam - two surfaces, primary or permanent | No Cost |
| D2160 | Amalgam - three surfaces, primary or permanent | No Cost |
| D2161 | Amalgam - four or more surfaces, primary or permanent | No Cost |
| D2330 | Resin-based composite - one surface, anterior | $30.00 |
| D2331 | Resin-based composite - two surfaces, anterior | $37.00 |
| D2332 | Resin-based composite - three surfaces, anterior | $45.00 |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | $65.00 |
| D2390 | Resin-based composite crown, anterior | $65.00 |
| D2391 | Resin-based composite - one surface, posterior | $55.00 |
| D2392 | Resin-based composite - two surfaces, posterior | $60.00 |
| D2393 | Resin-based composite - three surfaces, posterior | $65.00 |
| D2394 | Resin-based composite - four or more surfaces, posterior | $70.00 |
| D2510 | Inlay - metallic - one surface | $85.00 |
| D2520 | Inlay - metallic - two surfaces | $95.00 |
| D2530 | Inlay - metallic - three or more surfaces | $120.00 |
| D2542 | Onlay - metallic - two surfaces | $110.00 |
| D2543 | Onlay - metallic - three surfaces | $130.00 |
| D2544 | Onlay - metallic - four or more surfaces | $140.00 |
| D2610 | Inlay - porcelain/ceramic - one surface | $270.00 |
| D2620 | Inlay - porcelain/ceramic - two surfaces | $305.00 |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces | $325.00 |
| D2642 | Onlay - porcelain/ceramic - two surfaces | $300.00 |
| D2643 | Onlay - porcelain/ceramic - three surfaces | $335.00 |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces | $355.00 |
| D2650 | Inlay - resin-based composite - one surface | $170.00 |
| D2651 | Inlay - resin-based composite - two surfaces | $195.00 |
| D2652 | Inlay - resin-based composite - three or more surfaces | $230.00 |
| D2662 | Onlay - resin-based composite - two surfaces | $225.00 |
| D2663 | Onlay - resin-based composite - three surfaces | $250.00 |
| D2664 | Onlay - resin-based composite - four or more surfaces | $295.00 |
| D2710 | Crown - resin-based composite (indirect) | $120.00 |
| D2712 | Crown - ¾ resin-based composite (indirect) | $120.00 |
| D2720 | Crown - resin with high noble metal | $325.00 |
| D2721 | Crown - resin with predominantly base metal | $225.00 |
| D2722 | Crown - resin with noble metal | $225.00 |
| D2740 | Crown - porcelain/ceramic substrate | $375.00 |
| D2750 | Crown - porcelain fused to high noble metal | $375.00 |
| D2751 | Crown - porcelain fused to predominantly base metal | $275.00 |
| D2752 | Crown - porcelain fused to noble metal | $275.00 |
| D2780 | Crown - ¾ cast high noble metal | $295.00 |
| D2781 | Crown - ¾ cast predominantly base metal | $195.00 |

| | | |
|---|---|---|
| D2782 | Crown - ¾ cast noble metal | $195.00 |
| D2790 | Crown - full cast high noble metal | $310.00 |
| D2791 | Crown - full cast predominantly base metal | $210.00 |
| D2792 | Crown - full cast noble metal | $210.00 |
| D2794 | Crown - titanium | $325.00 |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | $10.00 |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | $10.00 |
| D2920 | Re-cement or re-bond crown | $10.00 |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp *(anterior)* | $65.00 |
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth - *anterior* | $45.00 |
| D2930 | Prefabricated stainless steel crown - primary tooth | $45.00 |
| D2931 | Prefabricated stainless steel crown - permanent tooth | $45.00 |
| D2932 | Prefabricated resin crown - *anterior primary tooth* | $55.00 |
| D2933 | Prefabricated stainless steel crown with resin window - *anterior primary tooth* | $45.00 |
| D2940 | Protective restoration | $15.00 |
| D2941 | Interim therapeutic restoration - primary dentition | $15.00 |
| D2949 | Restorative foundation for an indirect restoration | $40.00 |
| D2950 | Core buildup, including any pins when required | $40.00 |
| D2951 | Pin retention - per tooth, in addition to restoration | $12.00 |
| D2952 | Post and core in addition to crown, indirectly fabricated - *includes canal preparation* | $90.00 |
| D2953 | Each additional indirectly fabricated post - same tooth - *includes canal preparation* | $35.00 |
| D2954 | Prefabricated post and core in addition to crown - *base metal post; includes canal preparation* | $75.00 |
| D2957 | Each additional prefabricated post - same tooth - *base metal post; includes canal preparation* | $25.00 |
| D2970 | Temporary crown (fractured tooth) - *palliative treatment only* | $20.00 |
| D2980 | Crown repair necessitated by restorative material failure | $20.00 |
| D2981 | Inlay repair necessitated by restorative material failure | $20.00 |
| D2982 | Onlay repair necessitated by restorative material failure | $20.00 |
| D2983 | Veneer repair necessitated by restorative material failure | $20.00 |
| D2990 | Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15* | $7.00 |

**D3000-D3999 IV. ENDODONTICS - (*When services are provided by a Contract Specialist, the Enrollee pays the copayment noted*) ***

| | | |
|---|---|---|
| D3110 | Pulp cap - direct (excluding final restoration) | $12.00 |
| D3120 | Pulp cap - indirect (excluding final restoration) | $12.00 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | $30.00 |
| D3221 | Pulpal debridement, primary and permanent teeth | $30.00 |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | $30.00 |
| D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | $30.00 |
| D3310 | *Root canal* - endodontic therapy, anterior tooth (excluding final restoration) | $80.00 |
| D3320 | *Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration) | $140.00 |
| D3330 | *Root canal* - endodontic therapy, molar (excluding final restoration) | $200.00 |
| D3346 | Retreatment of previous root canal therapy - anterior | $360.00 |
| D3347 | Retreatment of previous root canal therapy - bicuspid | $475.00 |
| D3348 | Retreatment of previous root canal therapy - molar | $580.00 |
| D3410 | Apicoectomy - anterior | $95.00 |
| D3421 | Apicoectomy - bicuspid (first root) | $95.00 |
| D3425 | Apicoectomy - molar (first root) | $95.00 |
| D3426 | Apicoectomy (each additional root) | $50.00 |
| D3427 | Periradicular surgery without apicoectomy | $95.00 |
| D3430 | Retrograde filling - per root | $50.00 |
| D3450 | Root amputation - per root | $60.00 |

**D4000-D4999 V. PERIODONTICS - (*When services are provided by a Contract Specialist, the Enrollee pays the copayment noted*) ***

*- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

| | | |
|---|---|---|
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | $120.00 |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | $36.00 |

| | | |
|---|---|---|
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | $36.00 |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | $300.00 |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | $300.00 |
| D4277 | Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft | $215.00 |
| D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site | $215.00 |
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* | $45.00 |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* | $45.00 |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months* | $35.00 |
| D4910 | Periodontal maintenance - *limited to 1 treatment each 6 month period* | $45.00 |
| D4910 | *Additional periodontal maintenance (within the 6 month period)* | $65.00 |
| D4921 | Gingival irrigation - per quadrant | No Cost |

**D5000-D5899 VI. PROSTHODONTICS (removable)**

*- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.*
*- Relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.*
*- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.*

| | | |
|---|---|---|
| D5110 | Complete denture - maxillary | $260.00 |
| D5120 | Complete denture - mandibular | $260.00 |
| D5130 | Immediate denture - maxillary | $280.00 |
| D5140 | Immediate denture - mandibular | $280.00 |
| D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | $280.00 |
| D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | $280.00 |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $350.00 |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $295.00 |
| D5225 | Maxillary partial denture - flexible base (including any clasps, rests and teeth) | $570.00 |
| D5226 | Mandibular partial denture - flexible base (including any clasps, rests and teeth) | $570.00 |
| D5410 | Adjust complete denture - maxillary | $15.00 |
| D5411 | Adjust complete denture - mandibular | $15.00 |
| D5421 | Adjust partial denture - maxillary | $15.00 |
| D5422 | Adjust partial denture - mandibular | $15.00 |
| D5510 | Repair broken complete denture base | $54.00 |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | $32.00 |
| D5610 | Repair resin denture base | $54.00 |
| D5620 | Repair cast framework | $60.00 |
| D5630 | Repair or replace broken clasp | $54.00 |
| D5640 | Replace broken teeth - per tooth | $32.00 |
| D5650 | Add tooth to existing partial denture | $60.00 |
| D5660 | Add clasp to existing partial denture | $40.00 |
| D5730 | Reline complete maxillary denture (chairside) | $45.00 |
| D5731 | Reline complete mandibular denture (chairside) | $45.00 |
| D5740 | Reline maxillary partial denture (chairside) | $45.00 |
| D5741 | Reline mandibular partial denture (chairside) | $45.00 |
| D5750 | Reline complete maxillary denture (laboratory) | $125.00 |
| D5751 | Reline complete mandibular denture (laboratory) | $125.00 |
| D5760 | Reline maxillary partial denture (laboratory) | $125.00 |
| D5761 | Reline mandibular partial denture (laboratory) | $125.00 |
| D5820 | Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months* | $115.00 |
| D5821 | Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months* | $115.00 |

| | | |
|---|---|---|
| D5850 | Tissue conditioning, maxillary | $25.00 |
| D5851 | Tissue conditioning, mandibular | $25.00 |

**D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered**

**D6000-D6199 VIII. IMPLANT SERVICES - Not Covered**

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

*- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $125.00 per unit, beyond the 6th unit.*
*- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*

| | | |
|---|---|---|
| D6210 | Pontic - cast high noble metal | $310.00 |
| D6211 | Pontic - cast predominantly base metal | $210.00 |
| D6212 | Pontic - cast noble metal | $210.00 |
| D6240 | Pontic - porcelain fused to high noble metal | $375.00 |
| D6241 | Pontic - porcelain fused to predominantly base metal | $275.00 |
| D6242 | Pontic - porcelain fused to noble metal | $275.00 |
| D6245 | Pontic - porcelain/ceramic | $375.00 |
| D6250 | Pontic - resin with high noble metal | $375.00 |
| D6251 | Pontic - resin with predominantly base metal | $275.00 |
| D6252 | Pontic - resin with noble metal | $275.00 |
| D6600 | Inlay - porcelain/ceramic, two surfaces | $305.00 |
| D6601 | Inlay - porcelain/ceramic, three or more surfaces | $325.00 |
| D6602 | Inlay - cast high noble metal, two surfaces | $255.00 |
| D6603 | Inlay - cast high noble metal, three or more surfaces | $265.00 |
| D6604 | Inlay - cast predominantly base metal, two surfaces | $155.00 |
| D6605 | Inlay - cast predominantly base metal, three or more surfaces | $165.00 |
| D6606 | Inlay - cast noble metal, two surfaces | $185.00 |
| D6607 | Inlay - cast noble metal, three or more surfaces | $195.00 |
| D6608 | Onlay - porcelain/ceramic, two surfaces | $300.00 |
| D6609 | Onlay - porcelain/ceramic, three or more surfaces | $335.00 |
| D6610 | Onlay - cast high noble metal, two surfaces | $260.00 |
| D6611 | Onlay - cast high noble metal, three or more surfaces | $270.00 |
| D6612 | Onlay - cast predominantly base metal, two surfaces | $160.00 |
| D6613 | Onlay - cast predominantly base metal, three or more surfaces | $170.00 |
| D6614 | Onlay - cast noble metal, two surfaces | $190.00 |
| D6615 | Onlay - cast noble metal, three or more surfaces | $200.00 |
| D6720 | Crown - resin with high noble metal | $375.00 |
| D6721 | Crown - resin with predominantly base metal | $275.00 |
| D6722 | Crown - resin with noble metal | $275.00 |
| D6740 | Crown - porcelain/ceramic | $375.00 |
| D6750 | Crown - porcelain fused to high noble metal | $375.00 |
| D6751 | Crown - porcelain fused to predominantly base metal | $275.00 |
| D6752 | Crown - porcelain fused to noble metal | $275.00 |
| D6780 | Crown - ¾ cast high noble metal | $295.00 |
| D6781 | Crown - ¾ cast predominantly base metal | $195.00 |
| D6782 | Crown - ¾ cast noble metal | $195.00 |
| D6790 | Crown - full cast high noble metal | $310.00 |
| D6791 | Crown - full cast predominantly base metal | $210.00 |
| D6792 | Crown - full cast noble metal | $210.00 |
| D6930 | Re-cement or re-bond fixed partial denture | $10.00 |
| D6940 | Stress breaker | $35.00 |
| D6980 | Fixed partial denture repair necessitated by restorative material failure | $25.00 |

**D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY - (*When services are provided by a Contract Specialist, the Enrollee pays the copayment noted*) ***

*- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

| | | |
|---|---|---|
| D7111 | Extraction, coronal remnants - deciduous tooth | No Cost |
| D7111 | Extraction, coronal remnants - deciduous tooth *(each additional)* | $5.00 |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | No Cost |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) *(each additional)* | $5.00 |
| D7210 | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | $25.00 |
| D7220 | Removal of impacted tooth - soft tissue | $40.00 |
| D7230 | Removal of impacted tooth - partially bony | $60.00 |
| D7240 | Removal of impacted tooth - completely bony | $75.00 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | $75.00 |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | $25.00 |
| D7251 | Coronectomy - intentional partial tooth removal | $75.00 |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | $20.00 |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | $20.00 |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | $50.00 |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | $50.00 |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | $20.00 |
| D7960 | Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure | No Cost |

**D8000-D8999 XI. ORTHODONTICS**

*- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $75.00, may apply.*
*- The Retention Copayment includes adjustments and/or office visits up to 24 months.*

***Pre and post orthodontic records include:***

| | | |
|---|---|---|
| | *The benefit for pre-treatment records and diagnostic services includes:* | $250.00 |
| D0210 | Intraoral - complete series of radiographic images | |
| D0322 | Tomographic survey | |
| D0330 | Panoramic radiographic image | |
| D0340 | Cephalometric radiographic image | |
| D0350 | 2D oral/facial photographic images obtained intraorally or extraorally | |
| D0351 | 3D photographic image | |
| D0470 | Diagnostic casts | |
| | *The benefit for post-treatment records includes:* | $120.00 |
| D0210 | Intraoral - complete series of radiographic images | |
| D0470 | Diagnostic casts | |
| D8010 | Limited orthodontic treatment of the primary dentition | $1,150.00 |
| D8020 | Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19* | $1,150.00 |
| D8030 | Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19* | $1,150.00 |
| D8040 | Limited orthodontic treatment of the adult dentition - *adults, including dependent adult children covered from age 19 to 25* | $1,350.00 |
| D8050 | Interceptive orthodontic treatment of the primary dentition | $1,150.00 |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | $1,150.00 |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* | $1,650.00 |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* | $1,650.00 |
| D8090 | Comprehensive orthodontic treatment of the adult dentition - *adults, including dependent adult children covered as full-time students* | $1,850.00 |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development | $25.00 |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of *removable* retainers) | No Cost |
| D8999 | Unspecified orthodontic procedure, by report - *includes treatment planning session* | $350.00 |

**D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES - (*When services are provided by a Contract Specialist, the Enrollee pays the copayment noted*) ***

| | | |
|---|---|---|
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | $20.00 |
| D9211 | Regional block anesthesia | No Cost |

| | | |
|---|---|---|
| D9212 | Trigeminal division block anesthesia | No Cost |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | No Cost |
| D9219 | Evaluation for deep sedation or general anesthesia | No Cost |
| D9220 | Deep sedation/general anesthesia - first 30 minutes | $195.00 |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes | $95.00 |
| D9241 | Intravenous moderate (conscious) sedation/analgesia - first 30 minutes | $195.00 |
| D9242 | Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes | $95.00 |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | $50.00 |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | $5.00 |
| D9440 | Office visit - after regularly scheduled hours | $35.00 |
| D9450 | Case presentation, detailed and extensive treatment planning | $5.00 |
| D9931 | Cleaning and inspection of a removable appliance | No Cost |
| D9940 | Occlusal guard, by report - *limited to 1 in 3 years* | $115.00 |
| D9951 | Occlusal adjustment, limited | $25.00 |
| D9952 | Occlusal adjustment, complete | $135.00 |
| D9975 | External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment* | $125.00 |
| D9986 | Missed appointment - *without 24 hour notice - per 15 minutes of appointment time* | $10.00 |
| D9987 | Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time* | $10.00 |

All procedures listed may not be performed by the participating Contract Dentist selected by the Enrollee. The copayments shown apply to those DeltaCare USA participating Contract Dentists and participating Contract Specialists who perform those services. Therefore, the Enrollee is encouraged to discuss availability of the scheduled services with their participating Contract Dentist. Procedures not listed that are performed by the participating Contract Dentist will be charged at the Contract Dentist's "filed fees" less 25%. Coverage for second opinions to determine the appropriateness of a treatment plan are covered at no cost to the enrollee.

* Should the Enrollee need a specialist (endodontist, orthodontist, oral surgeon, periodontist or pediatric dentist), they may be referred by their participating Contract Dentist. Copayment amounts are applicable when treatment is performed by participating Contract Dentists or participating Contract Specialists. Benefits for procedures not listed on the schedule of benefits that are performed by a participating Contract Specialist are available at the participating Contract Specialist's "filed fee" less 25%. Specialist services are available only in areas where Delta Dental has a participating Contract Specialist.

"Filed fees" means the Contract Dentist's or Contract Specialist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

**SCHEDULE B**

**Limitations of Benefits**

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments* that are performed by a participating Contract Dentist or participating Contract Specialist will be charged at 75% of the Contract Dentist or Contract Specialists filed fee.
3. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $125.00 above the listed Copayment for each of these services after the sixth unit has been provided.
4. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
5. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
6. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
7. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
8. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

**Exclusions of Benefits**

1. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
2. Services solely for cosmetic purposes, with the exception of procedure D9975, (External bleaching for home application, per arch), abrasions, attrition, erosion or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
3. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
4. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations for non-covered benefits.
9. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Certificate of Coverage.

10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Prescription drugs.
12. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
13. Lost, stolen or broken orthodontic appliances.
14. Changes in orthodontic treatment necessitated by accident of any kind.
15. Myofunctional and parafunctional appliances and/or therapies.
16. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
17. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
18. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.
19. Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
20. Treatment required by reason of war, declared or undeclared.
21. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
22. Retained primary teeth shall be covered as primary teeth.

**Accident Injury Benefit**

An accidental injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under *Schedule A, Description of Benefits and Copayments*.

Delta Dental will pay up to 100% of the Contract Dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a Maximum of $1,600.00 in any 12 month period.

Accident injury benefits include the following procedure in addition to those listed in *Schedule A, Description of Benefits and Copayments*.

CODE

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization.

Payment of accident injury benefits is subject to *Schedule B, Limitations and Exclusions of Benefits*, in addition to the following provisions:

MAXIMUM

Accident injury benefits will be provided for each Enrollee up to a maximum of $1,600.00 in any 12 month period.

LIMITATION

Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.

EXCLUSIONS OF BENEFITS

In addition to *Schedule B*, exclusions #1-8, #10-12, 14, 18-22, the following limitations and exclusions also apply:

1. Prophylaxis.
2. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the Contract Dentist is not performing root canal therapy.

3. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
    - The replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture **or**
    - The replacement of permanent tooth/teeth for children under 16 years of age.
4. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
5. Replacement of existing restorations due to decay.
6. Orthodontic services (treatment of malalignment of teeth and/or jaws).
7. Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.
8. Procedures not shown on *Schedule A* other than D7270 as noted above.

**SmileWay® Wellness Program**

Find all of our dental health resources, including a risk assessment tool, articles, videos and a free e-newsletter subscription, at: **mysmileway.com**.

**DeltaCare USA Customer Service**

800-422-4234

**NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN.**

The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. A Certificate of Coverage will be sent to you upon enrollment. **If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.**

*In Florida, DeltaCare USA is underwritten and administered by Delta Dental Insurance Company.*

**Customer Service**
800-422-4234
Monday through Friday
8 a.m. to 9 p.m., Eastern time

*Provided by:*
**Delta Dental Insurance Company**
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

DELTA DENTAL®

**deltadentalins.com/enrollees**

# VI. DENTAL INSURANCE

## C. DELTA DENTAL PPO DENTAL PLAN (PREFERRED PROVIDER ORGANIZATION)

**Plan Benefit Highlights for:** Orange County Public Schools

**Group No:** 01552

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

| | | | |
|---|---|---|---|
| **Eligibility** | Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the yea dependent turns age age 26 | | |
| **Deductibles** | In-Network: $25 per person / $75 per family each calendar year<br>Out-of-Network: $50 per person / $150 per family each calendar year | | |
| Deductibles waived for D & P? | Yes | | |
| **Maximums** | $1,300 per person each calendar year | | |
| D & P counts toward maximum? | No | | |
| **Waiting Period(s)** | Basic Benefits<br>0 Months | Major Benefits<br>0 Months | Orthodontics<br>0 Months |

| **Benefits and Covered Services*** | **Delta Dental PPO dentists**** | **Non-Delta Dental PPO dentists**** |
|---|---|---|
| **Diagnostic & Preventive Services (D & P)**<br>Exams, cleanings, fluoride treatment, space maintainers, sealants and x-rays | 100 % | 80 % |
| **Basic Services**<br>Fillings | 80 % | 60 % |
| **Endodontics** (root canals)<br>Covered Under Basic Services | 80 % | 60 % |
| **Periodontics** (gum treatment)<br>Covered Under Basic Services | 80 % | 60 % |
| **Oral Surgery**<br>Incisions, excisions and surgical removal of tooth<br>Covered Under Basic Services | 80 % | 60 % |
| **Major Services**<br>Crowns, inlays, onlays and cast restorations, Major Endodontics and Major Periodontics | 50 % | 40 % |
| **Prosthodontics**<br>Bridges and dentures | 50 % | 40 % |

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055

**Customer Service**
800-932-0783

**Claims Address**
P.O. Box 2105
Mechanicsburg, PA 17055-6999

**deltadentalins.com**

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

# *Delta Dental PPO Plan*
# *Frequently Asked Questions*

**1. What is my deductible?**

Your deductible will vary depending on whether or not you choose to use a participating Delta Dental PPO provider. When using the in-network PPO dentist, you will have a $25 calendar year deductible (maximum $75 per family). When using the out-of-network dentist you will have a $50 calendar year deductible (maximum $150 per family). The deductible is waived for Preventive and Diagnostic procedures.

**2. What is my maximum benefit?**

The maximum benefit payable is $1,300 per covered enrollee per calendar year.

*Your plan includes the D&P Maximum Waiver benefit allowing you to obtain diagnostic and preventive dental services without those costs applying to the plan year maximum.*

**3. Who submits my claim – me or the dentist?**

Delta Dental dentists will file all claim forms for the enrollee and accept payment directly from Delta Dental.

**4. Who gets paid – me or the dentist?**

Participating dentists accept payment directly from Delta Dental. Delta Dental pays patients for claims processed if the patients visit a non-network dentist who does not file the enrollee's claim, or if the assignment of benefits to the non-network dentist was not indicated on the claim.

**5. How are benefits coordinated if I am covered under more than one policy?**

If enrollees are covered under more than one plan, Delta Dental's coordination of benefits (COB) procedures follow the industry standard "birthday rule". The insurance carrier covering the primary insured will be the first carrier responsible to pay the primary insured's claims. For covered dependent children, the birthday rule is applied. Under this rule, the company insuring the parent whose birthday falls earliest in each calendar year will pay claims first. The remaining amount may be reimbursed by the secondary insurer, up to 100% of the *procedure (individual contract requirements may supersede).* Delta Dental returns all claims that do not include coordination of benefit information to the dental office, and sends a copy of the missing information letter to the patient.

**6. How do I obtain a claim form?**

We can provide School Board of Orange County a supply of claim forms; however, a company-specific claim form is not required. Claim forms may also be obtained by visiting our web site at www.deltadentalins.com.

**7. How long do I have to file a claim?**

All claims are to be filed within one (1) year from the date of service.

DELTA DENTAL

**Delta Dental PPO Schedule of Benefits**
Orlando, Tampa, & St. Petersburg Areas Only
Covering Zip Codes 327, 328, 335 - 337, 342, 346, 347

| Procedure | Description | Maximum* Allowable Charge | Maximum** Reimbursement In Network | Maximum** Reimbursement Out of Network |
|---|---|---|---|---|
| **DIAGNOSTIC (Deductible does not apply) Clinical Oral Evaluations** | | | | |
| D0120 | periodic oral evaluation - established patient | $24.00 | $24.00 | $19.20 |
| D0140 | limited oral evaluation - problem focused | $40.00 | $40.00 | $32.00 |
| D0145 | oral evaluation for a patient under three years of age and counseling with primary caregiver | $24.00 | $24.00 | $19.20 |
| D0150 | comprehensive oral evaluation - new or established patient | $39.00 | $39.00 | $31.20 |
| D0160 | detailed and extensive oral evaluation - problem focused, by report | $64.00 | $64.00 | $51.20 |
| D0170 | re-evaluation - limited, problem focused (established patient; not post-operative visit) | $40.00 | $40.00 | $32.00 |
| D0171 | re-evaluation – post-operative office visit | $40.00 | $40.00 | $32.00 |
| D0180 | comprehensive periodontal evaluation - new or established patient | $49.00 | $49.00 | $39.20 |
| D0190 | screening of a patient | $17.00 | $17.00 | $13.60 |
| D0191 | assessment of a patient | $17.00 | $17.00 | $13.60 |
| **Radiographs/Diagnostic Imaging (Including Interpretation) (Any combination of bitewings, periapicals, and panoramic films taken on the same day will be combined as a complete series) (Deductible does not apply)** | | | | |
| D0210 | intraoral - complete series of radiographic images | $75.00 | $75.00 | $60.00 |
| D0220 | intraoral - periapical first radiographic image | $15.00 | $15.00 | $12.00 |
| D0230 | intraoral - periapical each additional radiographic image | $12.00 | $12.00 | $9.60 |
| D0240 | intraoral - occlusal radiographic image | $17.00 | $17.00 | $13.60 |
| D0250 | extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector | $21.00 | $21.00 | $16.80 |
| D0270 | bitewing - single radiographic image | $15.00 | $15.00 | $12.00 |
| D0272 | bitewings - two radiographic images | $22.00 | $22.00 | $17.60 |
| D0273 | bitewings - three radiographic images | $27.00 | $27.00 | $21.60 |
| D0274 | bitewings - four radiographic images | $31.00 | $31.00 | $24.80 |
| D0277 | vertical bitewings - 7 to 8 radiographic images | $32.00 | $32.00 | $25.60 |
| D0290 | posterior-anterior or lateral skull and facial bone survey radiographic image | $64.00 | $64.00 | $51.20 |
| D0310 | sialography | $299.00 | $299.00 | $239.20 |
| D0320 | temporomandibular joint arthrogram, including injection | $234.00 | $234.00 | $187.20 |
| D0321 | other temporomandibular joint radiographic images, by report | $73.00 | $73.00 | $58.40 |
| D0322 | tomographic survey | $258.00 | $258.00 | $206.40 |
| D0330 | panoramic radiographic image | $64.00 | $64.00 | $51.20 |
| D0340 | 2D cephalometric radiographic image – acquisition, measurement and analysis | $59.00 | $59.00 | $47.20 |
| D0350 | 2D oral/facial photographic image obtained intra-orally or extra-orally | $33.00 | $33.00 | $26.40 |
| D0351 | 3D photographic image | $32.00 | $32.00 | $25.60 |
| D0364 | cone beam CT capture and interpretation with limited field of view – less than one whole jaw | $193.00 | $193.00 | $154.40 |
| D0365 | cone beam CT capture and interpretation with field of view of one full dental arch – mandible | $235.00 | $235.00 | $188.00 |
| D0366 | cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium | $228.00 | $228.00 | $182.40 |
| D0367 | cone beam CT capture and interpretation with field of view of both jaws, with or without cranium | $301.00 | $301.00 | $240.80 |
| D0368 | cone beam CT capture and interpretation for TMJ series including two or more exposures | $125.00 | $125.00 | $100.00 |
| D0369 | maxillofacial MRI capture and interpretation | $159.00 | $159.00 | $127.20 |

* The maximum allowable fee for each dental procedure agreed to by Delta Dental PPO providers - not applicable to specialists.
** The maximum Delta Dental will pay for each dental procedure – not applicable to specialists.

| Procedure | Description | Maximum* Allowable Charge | Maximum** Reimbursement In Network | Maximum** Reimbursement Out of Network |
|---|---|---|---|---|
| D0370 | maxillofacial ultrasound capture and interpretation | $64.00 | $64.00 | $51.20 |
| D0371 | sialoendoscopy capture and interpretation | $111.00 | $111.00 | $88.80 |
| D0380 | cone beam CT image capture with limited field of view – less than one whole jaw | $289.00 | $289.00 | $231.20 |
| D0381 | cone beam CT image capture with field of view of one full dental arch – mandible | $206.00 | $206.00 | $164.80 |
| D0382 | cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium | $285.00 | $285.00 | $228.00 |
| D0383 | cone beam CT image capture with field of view of both jaws, with or without cranium | $335.00 | $335.00 | $268.00 |
| D0384 | cone beam CT image capture for TMJ series including two or more exposures | $250.00 | $250.00 | $200.00 |
| D0385 | maxillofacial MRI image capture | $120.00 | $120.00 | $96.00 |
| D0386 | maxillofacial ultrasound image capture | $486.00 | $486.00 | $388.80 |
| D0391 | interpretation of diagnostic image by a practitioner not associated with capture of the image, including report | $122.00 | $122.00 | $97.60 |
| D0393 | treatment simulation using 3D image volume | $212.00 | $212.00 | $169.60 |
| D0394 | digital subtraction of two or more images or image volumes of the same modality | $251.00 | $251.00 | $200.80 |
| D0395 | fusion of two or more 3D image volumes of one or more modalities | $350.00 | $350.00 | $280.00 |
| D0415 | collection of microorganisms for culture and sensitivity | $21.00 | $21.00 | $16.80 |
| D0416 | viral culture | $77.00 | $77.00 | $61.60 |
| D0417 | collection and preparation of saliva sample for laboratory diagnostic testing | $139.00 | $139.00 | $111.20 |
| D0418 | analysis of saliva sample | $212.00 | $212.00 | $169.60 |
| D0425 | caries susceptibility tests | $88.00 | $88.00 | $70.40 |
| D0431 | adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | $32.00 | $32.00 | $25.60 |
| **Tests and Examinations (Deductible does not apply)** | | | | |
| D0460 | pulp vitality tests | $25.00 | $25.00 | $20.00 |
| D0470 | diagnostic casts | $52.00 | $52.00 | $41.60 |
| **Oral Pathology Laboratory (Deductible does not apply)** | | | | |
| D0472 | accession of tissue, gross examination, preparation and transmission of written report | $54.00 | $54.00 | $43.20 |
| D0473 | accession of tissue, gross and microscopic examination, preparation and transmission of written report | $88.00 | $88.00 | $70.40 |
| D0474 | accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report | $99.00 | $99.00 | $79.20 |
| D0475 | decalcification procedure | $75.00 | $75.00 | $60.00 |
| D0476 | special stains for microorganisms | $166.00 | $166.00 | $132.80 |
| D0477 | special stains, not for microorganisms | $139.00 | $139.00 | $111.20 |
| D0478 | immunohistochemical stains | $50.00 | $50.00 | $40.00 |
| D0479 | tissue in-situ hybridization, including interpretation | $15.00 | $15.00 | $12.00 |
| D0480 | accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report | $106.00 | $106.00 | $84.80 |
| D0481 | electron microscopy | $33.00 | $33.00 | $26.40 |
| D0482 | direct immunofluorescence | $31.00 | $31.00 | $24.80 |
| D0483 | indirect immunofluorescence | $273.00 | $273.00 | $218.40 |
| D0484 | consultation on slides prepared elsewhere | $80.00 | $80.00 | $64.00 |
| D0485 | consultation, including preparation of slides from biopsy material supplied by referring source | $711.00 | $711.00 | $568.80 |
| D0486 | laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report | $77.00 | $77.00 | $61.60 |
| D0502 | other oral pathology procedures, by report | $94.00 | $94.00 | $75.20 |

* The maximum allowable fee for each dental procedure agreed to by Delta Dental PPO providers - not applicable to specialists.
** The maximum Delta Dental will pay for each dental procedure – not applicable to specialists.

| Procedure | Description | Maximum* Allowable Charge | Maximum** Reimbursement In Network | Maximum** Reimbursement Out of Network |
|---|---|---|---|---|
| D0601 | caries risk assessment and documentation, with a finding of low risk | $5.00 | $5.00 | $4.00 |
| D0602 | caries risk assessment and documentation, with a finding of moderate risk | $5.00 | $5.00 | $4.00 |
| D0603 | caries risk assessment and documentation, with a finding of high risk | $5.00 | $5.00 | $4.00 |
| D0999 | unspecified diagnostic procedure, by report | $59.00 | $59.00 | $47.20 |
| **PREVENTIVE (Deductible does not apply)** | | | | |
| **Dental Prophylaxis** | | | | |
| D1110 | prophylaxis - adult | $54.00 | $54.00 | $43.20 |
| D1120 | prophylaxis - child | $33.00 | $33.00 | $26.40 |
| **Topical Fluoride Treatment (Office Procedure) (Deductible does not apply)** | | | | |
| D1206 | topical application of fluoride varnish | $20.00 | $20.00 | $16.00 |
| D1208 | topical application of fluoride – excluding varnish | $20.00 | $20.00 | $16.00 |
| D1310 | nutritional counseling for control of dental disease | $41.00 | $41.00 | $32.80 |
| D1320 | tobacco counseling for the control and prevention of oral disease | $32.00 | $32.00 | $25.60 |
| D1330 | oral hygiene instructions | $32.00 | $32.00 | $25.60 |
| **Other Preventive Services (Deductible does not apply)** | | | | |
| D1351 | sealant – per tooth | $26.00 | $26.00 | $20.80 |
| D1352 | preventive resin restoration in a moderate to high caries risk patient – permanent tooth | $32.00 | $32.00 | $25.60 |
| D1353 | sealant repair – per tooth | $26.00 | $26.00 | $20.80 |
| **Space Maintenance (Passive Appliances) (Deductible does not apply)** | | | | |
| D1510 | space maintainer - fixed - unilateral | $164.00 | $164.00 | $131.20 |
| D1515 | space maintainer - fixed - bilateral | $274.00 | $274.00 | $219.20 |
| D1520 | space maintainer - removable - unilateral | $199.00 | $199.00 | $159.20 |
| D1525 | space maintainer - removable - bilateral | $274.00 | $274.00 | $219.20 |
| D1550 | re-cement or re-bond space maintainer | $43.00 | $43.00 | $34.40 |
| D1555 | removal of fixed space maintainer | $43.00 | $43.00 | $34.40 |
| **RESTORATIVE** | | | | |
| **Amalgam Restorations (Including Polishing)** | | | | |
| D2140 | amalgam - one surface, primary or permanent | $67.00 | $53.60 | $40.20 |
| D2150 | amalgam - two surfaces, primary or permanent | $86.00 | $68.80 | $51.60 |
| D2160 | amalgam - three surfaces, primary or permanent | $103.00 | $82.40 | $61.80 |
| D2161 | amalgam - four or more surfaces, primary or permanent | $128.00 | $102.40 | $76.80 |
| **Resin-Based Composite Restorations - Direct** | | | | |
| D2330 | resin-based composite - one surface, anterior | $78.00 | $62.40 | $46.80 |
| D2331 | resin-based composite - two surfaces, anterior | $98.00 | $78.40 | $58.80 |
| D2332 | resin-based composite - three surfaces, anterior | $121.00 | $96.80 | $72.60 |
| D2335 | resin-based composite - four or more surfaces or involving incisal angle (anterior) | $143.00 | $114.40 | $85.80 |
| D2390 | resin-based composite crown, anterior | $180.00 | $144.00 | $108.00 |
| D2391 | resin-based composite - one surface, posterior | $90.00 | $72.00 | $54.00 |
| D2392 | resin-based composite - two surfaces, posterior | $117.00 | $93.60 | $70.20 |
| D2393 | resin-based composite - three surfaces, posterior | $150.00 | $120.00 | $90.00 |
| D2394 | resin-based composite - four or more surfaces, posterior | $179.00 | $143.20 | $107.40 |
| D2410 | gold foil - one surface | $193.00 | $154.40 | $115.80 |
| D2420 | gold foil - two surfaces | $316.00 | $252.80 | $189.60 |
| D2430 | gold foil - three surfaces | $390.00 | $312.00 | $234.00 |
| **Inlay/Onlay Restorations** | | | | |
| D2510 | inlay - metallic - one surface | $415.00 | $207.50 | $166.00 |
| D2520 | inlay - metallic - two surfaces | $474.00 | $237.00 | $189.60 |

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|---|---|---|---|---|
| D2530 | inlay - metallic - three or more surfaces | $518.00 | $259.00 | $207.20 |
| D2542 | onlay - metallic - two surfaces | $528.00 | $264.00 | $211.20 |
| D2543 | onlay - metallic - three surfaces | $608.00 | $304.00 | $243.20 |
| D2544 | onlay - metallic - four or more surfaces | $622.00 | $311.00 | $248.80 |
| D2610 | inlay - porcelain/ceramic - one surface | $457.00 | $228.50 | $182.80 |
| D2620 | inlay - porcelain/ceramic - two surfaces | $522.00 | $261.00 | $208.80 |
| D2630 | inlay - porcelain/ceramic - three or more surfaces | $570.00 | $285.00 | $228.00 |
| D2642 | onlay - porcelain/ceramic - two surfaces | $581.00 | $290.50 | $232.40 |
| D2643 | onlay - porcelain/ceramic - three surfaces | $669.00 | $334.50 | $267.60 |
| D2644 | onlay - porcelain/ceramic - four or more surfaces | $685.00 | $342.50 | $274.00 |
| D2650 | inlay - resin-based composite - one surface | $384.00 | $192.00 | $153.60 |
| D2651 | inlay - resin-based composite - two surfaces | $431.00 | $215.50 | $172.40 |
| D2652 | inlay - resin-based composite - three or more surfaces | $508.00 | $254.00 | $203.20 |
| D2662 | onlay - resin-based composite - two surfaces | $457.00 | $228.50 | $182.80 |
| D2663 | onlay - resin-based composite - three surfaces | $477.00 | $238.50 | $190.80 |
| D2664 | onlay - resin-based composite - four or more surfaces | $547.00 | $273.50 | $218.80 |
| **Crowns - Single Restorations Only** | | | | |
| D2710 | crown - resin-based composite (indirect) | $332.00 | $166.00 | $132.80 |
| D2712 | crown – ¾ resin-based composite (indirect) | $332.00 | $166.00 | $132.80 |
| D2720 | crown - resin with high noble metal | $586.00 | $293.00 | $234.40 |
| D2721 | crown - resin with predominantly base metal | $530.00 | $265.00 | $212.00 |
| D2722 | crown - resin with noble metal | $533.00 | $266.50 | $213.20 |
| D2740 | crown - porcelain/ceramic substrate | $747.00 | $373.50 | $298.80 |
| D2750 | crown - porcelain fused to high noble metal | $727.00 | $363.50 | $290.80 |
| D2751 | crown - porcelain fused to predominantly base metal | $588.00 | $294.00 | $235.20 |
| D2752 | crown - porcelain fused to noble metal | $629.00 | $314.50 | $251.60 |
| D2780 | crown - 3/4 cast high noble metal | $614.00 | $307.00 | $245.60 |
| D2781 | crown - 3/4 cast predominantly base metal | $595.00 | $297.50 | $238.00 |
| D2782 | crown - 3/4 cast noble metal | $603.00 | $301.50 | $241.20 |
| D2783 | crown – ¾ porcelain/ceramic | $620.00 | $310.00 | $248.00 |
| D2790 | crown - full cast high noble metal | $646.00 | $323.00 | $258.40 |
| D2791 | crown - full cast predominantly base metal | $557.00 | $278.50 | $222.80 |
| D2792 | crown - full cast noble metal | $603.00 | $301.50 | $241.20 |
| D2794 | crown - titanium | $664.00 | $332.00 | $265.60 |
| D2799 | provisional crown– further treatment or completion of diagnosis necessary prior to final impression | $159.00 | $79.50 | $63.60 |
| **Other Restorative Services** | | | | |
| D2910 | re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | $52.00 | $26.00 | $20.80 |
| D2915 | re-cement or re-bond indirectly fabricated or prefabricated post and core | $52.00 | $26.00 | $20.80 |
| D2920 | re-cement or re-bond crown | $52.00 | $26.00 | $20.80 |
| D2921 | reattachment of tooth fragment, incisal edge or cusp | $107.00 | $53.50 | $42.80 |
| D2929 | prefabricated porcelain/ceramic crown – primary tooth | $194.00 | $97.00 | $77.60 |
| D2930 | prefabricated stainless steel crown - primary tooth | $139.00 | $69.50 | $55.60 |
| D2931 | prefabricated stainless steel crown - permanent tooth | $158.00 | $79.00 | $63.20 |
| D2932 | prefabricated resin crown | $173.00 | $86.50 | $69.20 |
| D2933 | prefabricated stainless steel crown with resin window | $194.00 | $97.00 | $77.60 |
| D2934 | prefabricated esthetic coated stainless steel crown - primary tooth | $194.00 | $97.00 | $77.60 |
| D2940 | protective restoration | $54.00 | $27.00 | $21.60 |
| D2941 | interim therapeutic restoration – primary dentition | $54.00 | $27.00 | $21.60 |
| D2949 | restorative foundation for an indirect restoration | $169.00 | $84.50 | $67.60 |
| D2950 | core buildup, including any pins when required | $129.00 | $64.50 | $51.60 |
| D2951 | pin retention - per tooth, in addition to restoration | $31.00 | $15.50 | $12.40 |
| D2952 | post and core in addition to crown, indirectly fabricated | $194.00 | $97.00 | $77.60 |

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| D2953 | each additional indirectly fabricated post - same tooth | $117.00 | $58.50 | $46.80 |
| D2954 | prefabricated post and core in addition to crown | $162.00 | $81.00 | $64.80 |
| D2955 | post removal | $165.00 | $82.50 | $66.00 |
| D2957 | each additional prefabricated post - same tooth | $130.00 | $65.00 | $52.00 |
| D2960 | labial veneer (resin laminate) - chairside | $297.00 | $148.50 | $118.80 |
| D2961 | labial veneer (resin laminate) - laboratory | $456.00 | $228.00 | $182.40 |
| D2962 | labial veneer (porcelain laminate) - laboratory | $537.00 | $268.50 | $214.80 |
| D2971 | additional procedures to construct new crown under existing partial denture framework | $100.00 | $50.00 | $40.00 |
| D2975 | coping | $568.00 | $284.00 | $227.20 |
| D2980 | crown repair necessitated by restorative material failure | $129.00 | $64.50 | $51.60 |
| D2981 | inlay repair necessitated by restorative material failure | $143.00 | $71.50 | $57.20 |
| D2982 | onlay repair necessitated by restorative material failure | $400.00 | $200.00 | $160.00 |
| D2983 | veneer repair necessitated by restorative material failure | $196.00 | $98.00 | $78.40 |
| D2990 | resin infiltration of incipient smooth surface lesions | $85.00 | $42.50 | $34.00 |
| D2999 | unspecified restorative procedure, by report | $104.00 | $52.00 | $41.60 |
| **ENDODONTICS** | | | | |
| **Pulpotomy** | | | | |
| D3110 | pulp cap - direct (excluding final restoration) | $39.00 | $31.20 | $23.40 |
| D3120 | pulp cap - indirect (excluding final restoration) | $44.00 | $35.20 | $26.40 |
| D3220 | therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | $106.00 | $84.80 | $63.60 |
| D3221 | pulpal debridement, primary and permanent teeth | $123.00 | $98.40 | $73.80 |
| D3222 | partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | $103.00 | $82.40 | $61.80 |
| **Endodontic Therapy of Primary Teeth** | | | | |
| D3230 | pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | $141.00 | $112.80 | $84.60 |
| D3240 | pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | $154.00 | $123.20 | $92.40 |
| **Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care)** | | | | |
| D3310 | endodontic therapy, anterior tooth (excluding final restoration) | $418.00 | $334.40 | $250.80 |
| D3320 | endodontic therapy, bicuspid tooth (excluding final restoration) | $500.00 | $400.00 | $300.00 |
| D3330 | endodontic therapy, molar tooth (excluding final restoration) | $660.00 | $528.00 | $396.00 |
| D3331 | treatment of root canal obstruction; non-surgical access | $82.00 | $65.60 | $49.20 |
| D3332 | incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | $280.00 | $224.00 | $168.00 |
| D3333 | internal root repair of perforation defects | $121.00 | $96.80 | $72.60 |
| **Endodontic Retreatment** | | | | |
| D3346 | retreatment of previous root canal therapy - anterior | $523.00 | $418.40 | $313.80 |
| D3347 | retreatment of previous root canal therapy - bicuspid | $578.00 | $462.40 | $346.80 |
| D3348 | retreatment of previous root canal therapy - molar | $710.00 | $568.00 | $426.00 |
| **Apexification/Recalcification Procedures** | | | | |
| D3351 | apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.) | $200.00 | $160.00 | $120.00 |
| D3352 | apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | $116.00 | $92.80 | $69.60 |
| D3353 | apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | $306.00 | $244.80 | $183.60 |
| D3355 | pulpal regeneration - initial visit | $234.00 | $187.20 | $140.40 |
| D3356 | pulpal regeneration - interim medication replacement | $270.00 | $216.00 | $162.00 |

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| D3357 | pulpal regeneration - completion of treatment | $398.00 | $318.40 | $238.80 |
| **Apicoectomy/Periradicular Services** | | | | |
| D3410 | apicoectomy – anterior | $438.00 | $350.40 | $262.80 |
| D3421 | apicoectomy – bicuspid (first root) | $457.00 | $365.60 | $274.20 |
| D3425 | apicoectomy – molar (first root) | $557.00 | $445.60 | $334.20 |
| D3426 | apicoectomy (each additional root) | $202.00 | $161.60 | $121.20 |
| D3427 | periradicular surgery without apicoectomy | $129.00 | $103.20 | $77.40 |
| D3428 | bone graft in conjunction with periradicular surgery – per tooth, single site | $243.00 | $194.40 | $145.80 |
| D3429 | bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site | $343.00 | $274.40 | $205.80 |
| D3430 | retrograde filling - per root | $129.00 | $103.20 | $77.40 |
| D3431 | biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery | $1,050.00 | $840.00 | $630.00 |
| D3432 | guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery | $375.00 | $300.00 | $225.00 |
| D3450 | root amputation - per root | $290.00 | $232.00 | $174.00 |
| D3460 | endodontic endosseous implant | $1,126.00 | $900.80 | $675.60 |
| D3470 | intentional reimplantation (including necessary splinting) | $163.00 | $130.40 | $97.80 |
| **Other Endodontic Procedures** | | | | |
| D3910 | surgical procedure for isolation of tooth with rubber dam | $111.00 | $88.80 | $66.60 |
| D3920 | hemisection (including any root removal), not including root canal therapy | $221.00 | $176.80 | $132.60 |
| D3950 | canal preparation and fitting of preformed dowel or post | $149.00 | $119.20 | $89.40 |
| D3999 | unspecified endodontic procedure, by report | $203.00 | $162.40 | $121.80 |
| **PERIODONTICS** | | | | |
| **Surgical Services (Including Usual Postoperative Care)** | | | | |
| D4210 | gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | $350.00 | $280.00 | $210.00 |
| D4211 | gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | $211.00 | $168.80 | $126.60 |
| D4212 | gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | $211.00 | $168.80 | $126.60 |
| D4230 | anatomical crown exposure - four or more contiguous teeth per quadrant | $564.00 | $451.20 | $338.40 |
| D4231 | anatomical crown exposure - one to three teeth per quadrant | $476.00 | $380.80 | $285.60 |
| D4240 | gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | $429.00 | $343.20 | $257.40 |
| D4241 | gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | $294.00 | $235.20 | $176.40 |
| D4245 | apically positioned flap | $317.00 | $253.60 | $190.20 |
| D4249 | clinical crown lengthening – hard tissue | $437.00 | $349.60 | $262.20 |
| D4260 | osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant | $626.00 | $500.80 | $375.60 |
| D4261 | osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant | $437.00 | $349.60 | $262.20 |
| D4263 | bone replacement graft - first site in quadrant | $251.00 | $200.80 | $150.60 |
| D4264 | bone replacement graft - each additional site in quadrant | $250.00 | $200.00 | $150.00 |
| D4265 | biologic materials to aid in soft and osseous tissue regeneration | $408.00 | $326.40 | $244.80 |
| D4266 | guided tissue regeneration - resorbable barrier, per site | $410.00 | $328.00 | $246.00 |
| D4267 | guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal) | $513.00 | $410.40 | $307.80 |
| D4268 | surgical revision procedure, per tooth | $332.00 | $265.60 | $199.20 |

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| D4270 | pedicle soft tissue graft procedure | $475.00 | $380.00 | $285.00 |
| D4273 | autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft | $615.00 | $492.00 | $369.00 |
| D4274 | distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) | $326.00 | $260.80 | $195.60 |
| D4275 | non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft | $292.00 | $233.60 | $175.20 |
| D4276 | combined connective tissue and double pedicle graft, per tooth | $554.00 | $443.20 | $332.40 |
| D4277 | free soft tissue graft procedure (including recipient and donor surgical sites first tooth, implant, or edentulous tooth position in graft | $503.00 | $402.40 | $301.80 |
| D4278 | free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site | $377.00 | $301.60 | $226.20 |
| D4283 | autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | $369.00 | $295.20 | $221.40 |
| D4285 | non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | $175.00 | $140.00 | $105.00 |
| **Non-Surgical Periodontal Service** | | | | |
| D4320 | provisional splinting - intracoronal | $146.00 | $116.80 | $87.60 |
| D4321 | provisional splinting - extracoronal | $222.00 | $177.60 | $133.20 |
| D4341 | periodontal scaling and root planing - four or more teeth per quadrant | $130.00 | $104.00 | $78.00 |
| D4342 | periodontal scaling and root planing - one to three teeth per quadrant | $93.00 | $74.40 | $55.80 |
| D4355 | full mouth debridement to enable comprehensive evaluation and diagnosis | $54.00 | $43.20 | $32.40 |
| D4381 | localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth | $24.00 | $19.20 | $14.40 |
| **Other Periodontal Service** | | | | |
| D4910 | periodontal maintenance | $70.00 | $56.00 | $42.00 |
| D4920 | unscheduled dressing change (by someone other than treating dentist or their staff) | $49.00 | $39.20 | $29.40 |
| D4921 | gingival irrigation – per quadrant | $22.00 | $17.60 | $13.20 |
| D4999 | unspecified periodontal procedure, by report | $55.00 | $44.00 | $33.00 |
| **PROSTHODONTICS (Removable)** | | | | |
| **Complete Dentures (Including Routine Post-Delivery Care) (includes routine post-delivery care for the first six months after placement)** | | | | |
| D5110 | complete denture - maxillary | $862.00 | $431.00 | $344.80 |
| D5120 | complete denture - mandibular | $862.00 | $431.00 | $344.80 |
| D5130 | Immediate denture, maxillary | $949.00 | $474.50 | $379.60 |
| D5140 | Immediate dePartial Dentures (Including Routine Post-Delivery Care) (includes routine post-delivery care for the first six months after placement)nture, mandibular | $949.00 | $474.50 | $379.60 |
| **Partial Dentures (Including Routine Post-Delivery Care) (includes routine post-delivery care for the first six months after placement)** | | | | |
| D5211 | maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | $634.00 | $317.00 | $253.60 |

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| D5212 | mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | $634.00 | $317.00 | $253.60 |
| D5213 | maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $948.00 | $474.00 | $379.20 |
| D5214 | mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $948.00 | $474.00 | $379.20 |
| D5221 | immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | $761.00 | $380.50 | $304.40 |
| D5222 | immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) | $761.00 | $380.50 | $304.40 |
| D5223 | immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $1,138.00 | $569.00 | $455.20 |
| D5224 | immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $1,138.00 | $569.00 | $455.20 |
| D5225 | maxillary partial denture - flexible base (including any clasps, rests and teeth) | $711.00 | $355.50 | $284.40 |
| D5226 | mandibular partial denture - flexible base (including any clasps, rests and teeth) | $711.00 | $355.50 | $284.40 |
| D5281 | removable unilateral partial denture - one piece cast metal (including clasps and teeth) | $522.00 | $261.00 | $208.80 |
| **Adjustments to Dentures** | | | | |
| D5410 | adjust complete denture - maxillary | $43.00 | $21.50 | $17.20 |
| D5411 | adjust complete denture - mandibular | $43.00 | $21.50 | $17.20 |
| D5421 | adjust partial denture - maxillary | $43.00 | $21.50 | $17.20 |
| D5422 | adjust partial denture - mandibular | $43.00 | $21.50 | $17.20 |
| **Repairs to Complete Dentures** | | | | |
| D5510 | repair broken complete denture base | $105.00 | $52.50 | $42.00 |
| D5520 | replace missing or broken teeth - complete denture (each tooth) | $85.00 | $42.50 | $34.00 |
| **Repairs to Partial Dentures** | | | | |
| D5610 | repair resin denture base | $87.00 | $43.50 | $34.80 |
| D5620 | repair cast framework | $132.00 | $66.00 | $52.80 |
| D5630 | repair or replace broken clasp – per tooth | $127.00 | $63.50 | $50.80 |
| D5640 | replace broken teeth - per tooth | $85.00 | $42.50 | $34.00 |
| D5650 | add tooth to existing partial denture | $98.00 | $49.00 | $39.20 |
| D5660 | add clasp to existing partial denture – per tooth | $127.00 | $63.50 | $50.80 |
| D5670 | replace all teeth and acrylic on cast metal framework (maxillary) | $401.00 | $200.50 | $160.40 |
| D5671 | replace all teeth and acrylic on cast metal framework (mandibular) | $401.00 | $200.50 | $160.40 |
| **Denture Rebase Procedures** | | | | |
| D5710 | rebase complete maxillary denture | $263.00 | $131.50 | $105.20 |
| D5711 | rebase complete mandibular denture | $263.00 | $131.50 | $105.20 |
| D5720 | rebase maxillary partial denture | $254.00 | $127.00 | $101.60 |
| D5721 | rebase mandibular partial denture | $254.00 | $127.00 | $101.60 |
| **Denture Reline Procedures** | | | | |
| D5730 | reline complete maxillary denture (chairside) | $167.00 | $83.50 | $66.80 |
| D5731 | reline complete mandibular denture (chairside) | $167.00 | $83.50 | $66.80 |
| D5740 | reline maxillary partial denture (chairside) | $157.00 | $78.50 | $62.80 |
| D5741 | reline mandibular partial denture (chairside) | $157.00 | $78.50 | $62.80 |
| D5750 | reline complete maxillary denture (laboratory) | $217.00 | $108.50 | $86.80 |
| D5751 | reline complete mandibular denture (laboratory) | $217.00 | $108.50 | $86.80 |

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|---|---|---|---|---|
| D5760 | reline maxillary partial denture (laboratory) | $208.00 | $104.00 | $83.20 |
| D5761 | reline mandibular partial denture (laboratory) | $208.00 | $104.00 | $83.20 |
| **Interim Prosthesis** | | | | |
| D5810 | interim complete denture (maxillary) | $350.00 | $175.00 | $140.00 |
| D5811 | interim complete denture (mandibular) | $350.00 | $175.00 | $140.00 |
| D5820 | interim partial denture (maxillary) | $329.00 | $164.50 | $131.60 |
| D5821 | interim partial denture (mandibular) | $329.00 | $164.50 | $131.60 |
| **Other Removable Prosthetic Services** | | | | |
| D5850 | tissue conditioning, maxillary | $81.00 | $40.50 | $32.40 |
| D5851 | tissue conditioning, mandibular | $81.00 | $40.50 | $32.40 |
| D5862 | precision attachment, by report | $380.00 | $190.00 | $152.00 |
| D5863 | overdenture – complete maxillary | $862.00 | $431.00 | $344.80 |
| D5864 | overdenture – partial maxillary | $948.00 | $474.00 | $379.20 |
| D5865 | overdenture – complete mandibular | $862.00 | $431.00 | $344.80 |
| D5866 | overdenture – partial mandibular | $948.00 | $474.00 | $379.20 |
| D5867 | replacement of replaceable part of semi-precision or precision attachment (male or female component) | $105.00 | $52.50 | $42.00 |
| D5875 | modification of removable prosthesis following implant surgery | $162.00 | $81.00 | $64.80 |
| D5899 | unspecified removable prosthodontic procedure, by report | $476.00 | $238.00 | $190.40 |
| D5911 | facial moulage (sectional) | $150.00 | $75.00 | $60.00 |
| D5912 | facial moulage (complete) | $67.00 | $33.50 | $26.80 |
| D5913 | nasal prosthesis | $5,729.00 | $2,864.50 | $2,291.60 |
| D5914 | auricular prosthesis | $9,981.00 | $4,990.50 | $3,992.40 |
| D5915 | orbital prosthesis | $7,670.00 | $3,835.00 | $3,068.00 |
| D5916 | ocular prosthesis | $1,424.00 | $712.00 | $569.60 |
| D5919 | facial prosthesis | $800.00 | $400.00 | $320.00 |
| D5922 | nasal septal prosthesis | $135.00 | $67.50 | $54.00 |
| D5923 | ocular prosthesis, interim | $2,558.00 | $1,279.00 | $1,023.20 |
| D5924 | cranial prosthesis | $242.00 | $121.00 | $96.80 |
| D5925 | facial augmentation implant prosthesis | $850.00 | $425.00 | $340.00 |
| D5926 | nasal prosthesis, replacement | $545.00 | $272.50 | $218.00 |
| D5927 | auricular prosthesis, replacement | $150.00 | $75.00 | $60.00 |
| D5928 | orbital prosthesis, replacement | $450.00 | $225.00 | $180.00 |
| D5929 | facial prosthesis, replacement | $428.00 | $214.00 | $171.20 |
| D5931 | obturator prosthesis, surgical | $1,056.00 | $528.00 | $422.40 |
| D5932 | obturator prosthesis, definitive | $3,771.00 | $1,885.50 | $1,508.40 |
| D5933 | obturator prosthesis, modification | $338.00 | $169.00 | $135.20 |
| D5934 | mandibular resection prosthesis with guide flange | $750.00 | $375.00 | $300.00 |
| D5935 | mandibular resection prosthesis without guide flange | $6,362.00 | $3,181.00 | $2,544.80 |
| D5936 | obturator prosthesis, interim | $610.00 | $305.00 | $244.00 |
| D5937 | trismus appliance (not for TMD treatment) | $750.00 | $375.00 | $300.00 |
| D5951 | feeding aid | $195.00 | $97.50 | $78.00 |
| D5952 | speech aid prosthesis, pediatric | $500.00 | $250.00 | $200.00 |
| D5953 | speech aid prosthesis, adult | $1,200.00 | $600.00 | $480.00 |
| D5954 | palatal augmentation prosthesis | $250.00 | $125.00 | $100.00 |
| D5955 | palatal lift prosthesis, definitive | $7,694.00 | $3,847.00 | $3,077.60 |
| D5958 | palatal lift prosthesis, interim | $747.00 | $373.50 | $298.80 |
| D5959 | palatal lift prosthesis, modification | $384.00 | $192.00 | $153.60 |
| D5960 | speech aid prosthesis, modification | $223.00 | $111.50 | $89.20 |
| D5982 | surgical stent | $276.00 | $138.00 | $110.40 |
| D5983 | radiation carrier | $487.00 | $243.50 | $194.80 |
| D5984 | radiation shield | $429.00 | $214.50 | $171.60 |
| D5985 | radiation cone locator | $673.00 | $336.50 | $269.20 |
| D5986 | fluoride gel carrier | $118.00 | $59.00 | $47.20 |
| D5987 | commissure splint | $301.00 | $150.50 | $120.40 |

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| D5988 | surgical splint | $250.00 | $125.00 | $100.00 |
| D5991 | vesiculobullous disease medicament carrier | $495.00 | $247.50 | $198.00 |
| D5992 | adjust maxillofacial prosthetic appliance, by report | $82.00 | $41.00 | $32.80 |
| D5993 | maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report | $73.00 | $36.50 | $29.20 |
| D5994 | periodontal medicament carrier with peripheral seal – laboratory processed | $1,250.00 | $625.00 | $500.00 |
| D5999 | unspecified maxillofacial prosthesis, by report | $476.00 | $238.00 | $190.40 |
| **PROSTHODONTICS, FIXED** | | | | |
| **Fixed Partial Denture Pontics** | | | | |
| D6205 | pontic - indirect resin based composite | $674.00 | $337.00 | $269.60 |
| D6210 | pontic - cast high noble metal | $571.00 | $285.50 | $228.40 |
| D6211 | pontic - cast predominantly base metal | $490.00 | $245.00 | $196.00 |
| D6212 | pontic - cast noble metal | $560.00 | $280.00 | $224.00 |
| D6214 | pontic - titanium | $664.00 | $332.00 | $265.60 |
| D6240 | pontic - porcelain fused to high noble metal | $593.00 | $296.50 | $237.20 |
| D6241 | pontic - porcelain fused to predominantly base metal | $518.00 | $259.00 | $207.20 |
| D6242 | pontic - porcelain fused to noble metal | $534.00 | $267.00 | $213.60 |
| D6245 | pontic - porcelain/ceramic | $800.00 | $400.00 | $320.00 |
| D6250 | pontic - resin with high noble metal | $555.00 | $277.50 | $222.00 |
| D6251 | pontic - resin with predominantly base metal | $470.00 | $235.00 | $188.00 |
| D6252 | pontic - resin with noble metal | $518.00 | $259.00 | $207.20 |
| D6253 | provisional pontic– further treatment or completion of diagnosis necessary prior to final impression | $233.00 | $116.50 | $93.20 |
| **Fixed Partial Denture Retainers - Inlays/Onlays** | | | | |
| D6545 | retainer - cast metal for resin bonded fixed prosthesis | $434.00 | $217.00 | $173.60 |
| D6548 | retainer - porcelain/ceramic for resin bonded fixed prosthesis | $478.00 | $239.00 | $191.20 |
| D6549 | resin retainer –for resin bonded fixed prosthesis | $434.00 | $217.00 | $173.60 |
| D6600 | retainer inlay - porcelain/ceramic, two surfaces | $608.00 | $304.00 | $243.20 |
| D6601 | retainer inlay - porcelain/ ceramic - three or more surfaces | $637.00 | $318.50 | $254.80 |
| D6602 | retainer inlay - cast high noble metal, two surfaces | $552.00 | $276.00 | $220.80 |
| D6603 | retainer inlay - cast high noble metal, three or more surfaces | $579.00 | $289.50 | $231.60 |
| D6604 | retainer inlay - cast predominantly base metal, two surfaces | $518.00 | $259.00 | $207.20 |
| D6605 | retainer inlay – cast predominantly base metal, three or more surfaces | $523.00 | $261.50 | $209.20 |
| D6606 | retainer inlay – cast noble metal, two surfaces | $537.00 | $268.50 | $214.80 |
| D6607 | retainer inlay – cast noble metal – three or more surfaces | $551.00 | $275.50 | $220.40 |
| D6608 | retainer onlay - porcelain/ ceramic, two surfaces | $707.00 | $353.50 | $282.80 |
| D6609 | retainer onlay porcelain/ ceramic, three or more surfaces | $753.00 | $376.50 | $301.20 |
| D6610 | retainer onlay - cast high noble metal, two surfaces | $642.00 | $321.00 | $256.80 |
| D6611 | retainer onlay - cast high noble metal, three or more surfaces | $684.00 | $342.00 | $273.60 |
| D6612 | retainer onlay - cast predominantly base metal, two surfaces | $555.00 | $277.50 | $222.00 |
| D6613 | retainer onlay - cast predominantly base metal, three or more surfaces | $591.00 | $295.50 | $236.40 |
| D6614 | retainer onlay - cast noble metal, two surfaces | $583.00 | $291.50 | $233.20 |
| D6615 | retainer onlay - cast noble metal, three or more surfaces | $622.00 | $311.00 | $248.80 |
| D6624 | retainer Inlay – titanium | $579.00 | $289.50 | $231.60 |
| D6634 | retainer Onlay - titanium | $684.00 | $342.00 | $273.60 |
| **Fixed Partial Denture Retainers - Crowns** | | | | |
| D6710 | retainer crown - indirect resin based composite | $674.00 | $337.00 | $269.60 |
| D6720 | retainer crown - resin with high noble metal | $586.00 | $293.00 | $234.40 |
| D6721 | retainer crown - resin with predominantly base metal | $530.00 | $265.00 | $212.00 |
| D6722 | retainer crown - resin with noble metal | $533.00 | $266.50 | $213.20 |
| D6740 | retainer crown - porcelain/ceramic | $800.00 | $400.00 | $320.00 |
| D6750 | retainer crown - porcelain fused to high noble metal | $727.00 | $363.50 | $290.80 |

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| D6751 | retainer crown - porcelain fused to predominantly base metal | $588.00 | $294.00 | $235.20 |
| D6752 | retainer crown - porcelain fused to noble metal | $629.00 | $314.50 | $251.60 |
| D6780 | retainer crown - 3/4 cast high noble metal | $614.00 | $307.00 | $245.60 |
| D6781 | retainer crown - 3/4 cast predominantly base metal | $595.00 | $297.50 | $238.00 |
| D6782 | retainer crown - 3/4 cast noble metal | $603.00 | $301.50 | $241.20 |
| D6783 | retianer crown - 3/4 porcelain/ceramic | $800.00 | $400.00 | $320.00 |
| D6790 | retainer crown - full cast high noble metal | $646.00 | $323.00 | $258.40 |
| D6791 | retainer crown - full cast predominantly base metal | $557.00 | $278.50 | $222.80 |
| D6792 | retainer crown - full cast noble metal | $603.00 | $301.50 | $241.20 |
| D6793 | provisional retainer crown– further treatment or completion of diagnosis necessary prior to final impression | $233.00 | $116.50 | $93.20 |
| D6794 | retainer crown - titanium | $664.00 | $332.00 | $265.60 |
| **Other Fixed Partial Denture Services** | | | | |
| D6920 | connector bar | $221.00 | $110.50 | $88.40 |
| D6930 | re-cement or re-bond fixed partial denture | $78.00 | $39.00 | $31.20 |
| D6940 | stress breaker | $199.00 | $99.50 | $79.60 |
| D6950 | precision attachment | $384.00 | $192.00 | $153.60 |
| D6980 | fixed partial denture repair necessitated by restorative material failure | $299.00 | $149.50 | $119.60 |
| D6985 | pediatric partial denture, fixed | $260.00 | $130.00 | $104.00 |
| D6999 | unspecified fixed prosthodontic procedure, by report | $321.00 | $160.50 | $128.40 |
| **ORAL AND MAXILLOFACIAL SURGERY** | | | | |
| **Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)** | | | | |
| D7111 | extraction, coronal remnants - deciduous tooth | $58.00 | $46.40 | $34.80 |
| D7140 | extraction, erupted tooth or exposed root (elevation and/or forceps removal) | $77.00 | $61.60 | $46.20 |
| **Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)** | | | | |
| D7210 | surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | $131.00 | $104.80 | $78.60 |
| D7220 | removal of impacted tooth - soft tissue | $163.00 | $130.40 | $97.80 |
| D7230 | removal of impacted tooth - partially bony | $211.00 | $168.80 | $126.60 |
| D7240 | removal of impacted tooth - completely bony | $245.00 | $196.00 | $147.00 |
| D7241 | removal of impacted tooth - completely bony, with unusual surgical complications | $270.00 | $216.00 | $162.00 |
| D7250 | surgical removal of residual tooth roots (cutting procedure) | $141.00 | $112.80 | $84.60 |
| D7251 | coronectomy – intentional partial tooth removal | $368.00 | $294.40 | $220.80 |
| **Other Surgical Procedures** | | | | |
| D7260 | oroantral fistula closure | $924.00 | $739.20 | $554.40 |
| D7261 | primary closure of a sinus perforation | $924.00 | $739.20 | $554.40 |
| D7270 | tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | $247.00 | $197.60 | $148.20 |
| D7272 | tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) | $250.00 | $200.00 | $150.00 |
| D7280 | surgical access of an unerupted tooth | $302.00 | $241.60 | $181.20 |
| D7282 | mobilization of erupted or malpositioned tooth to aid eruption | $105.00 | $84.00 | $63.00 |
| D7283 | placement of device to facilitate eruption of impacted tooth | $105.00 | $84.00 | $63.00 |
| D7285 | incisional biopsy of oral tissue-hard (bone, tooth) | $265.00 | $212.00 | $159.00 |
| D7286 | incisional biopsy of oral tissue-soft | $164.00 | $131.20 | $98.40 |
| D7287 | exfoliative cytological sample collection | $172.00 | $137.60 | $103.20 |
| D7288 | brush biopsy - transepithelial sample collection | $99.00 | $79.20 | $59.40 |
| D7290 | surgical repositioning of teeth | $131.00 | $104.80 | $78.60 |
| D7291 | transseptal fiberotomy/supra crestal fiberotomy, by report | $75.00 | $60.00 | $45.00 |

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| D7292 | surgical placement of temporary anchorage device [screw retained plate] requiring flap; includes device removal | $970.00 | $776.00 | $582.00 |
| D7293 | surgical placement of temporary anchorage device requiring flap; includes device removal | $541.00 | $432.80 | $324.60 |
| D7294 | surgical placement of temporary anchorage device without flap; includes device removal | $833.00 | $666.40 | $499.80 |
| D7295 | harvest of bone for use in autogenous grafting procedure | $347.00 | $277.60 | $208.20 |
| **Alveoloplasty - Surgical Preparation of Ridge for Dentures** | | | | |
| D7310 | alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | $141.00 | $112.80 | $84.60 |
| D7311 | alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | $85.00 | $68.00 | $51.00 |
| D7320 | alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | $235.00 | $188.00 | $141.00 |
| D7321 | alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | $142.00 | $113.60 | $85.20 |
| **Vestibuloplasty** | | | | |
| D7340 | vestibuloplasty - ridge extension (secondary epithelialization) | $433.00 | $346.40 | $259.80 |
| D7350 | vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | $540.00 | $432.00 | $324.00 |
| **Surgical Excision of Soft Tissue Lesions** | | | | |
| D7410 | excision of benign lesion up to 1.25 cm | $253.00 | $202.40 | $151.80 |
| D7411 | excision of benign lesion greater than 1.25 cm | $385.00 | $308.00 | $231.00 |
| D7412 | excision of benign lesion, complicated | $423.00 | $338.40 | $253.80 |
| D7413 | excision of malignant lesion up to 1.25 cm | $457.00 | $365.60 | $274.20 |
| D7414 | excision of malignant lesion greater than 1.25 cm | $500.00 | $400.00 | $300.00 |
| D7415 | excision of malignant lesion, complicated | $721.00 | $576.80 | $432.60 |
| D7440 | excision of malignant tumor - lesion diameter up to 1.25 cm | $357.00 | $285.60 | $214.20 |
| D7441 | excision of malignant tumor - lesion diameter greater than 1.25 cm | $498.00 | $398.40 | $298.80 |
| **Surgical Excision of Intra-Osseous Lesions** | | | | |
| D7450 | removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | $328.00 | $262.40 | $196.80 |
| D7451 | removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm | $399.00 | $319.20 | $239.40 |
| D7460 | removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm | $303.00 | $242.40 | $181.80 |
| D7461 | removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm | $399.00 | $319.20 | $239.40 |
| D7465 | destruction of lesion(s) by physical or chemical method, by report | $193.00 | $154.40 | $115.80 |
| **Excision of Bone Tissue** | | | | |
| D7471 | removal of lateral exostosis (maxilla or mandible) | $496.00 | $396.80 | $297.60 |
| D7472 | removal of torus palatinus | $496.00 | $396.80 | $297.60 |
| D7473 | removal of torus mandibularis | $496.00 | $396.80 | $297.60 |
| D7485 | surgical reduction of osseous tuberosity | $496.00 | $396.80 | $297.60 |
| D7490 | radical resection of maxilla or mandible | $853.00 | $682.40 | $511.80 |
| **Surgical Incision** | | | | |
| D7510 | incision and drainage of abscess - intraoral soft tissue | $129.00 | $103.20 | $77.40 |
| D7511 | incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | $149.00 | $119.20 | $89.40 |
| D7520 | incision and drainage of abscess - extraoral soft tissue | $181.00 | $144.80 | $108.60 |
| D7521 | incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | $409.00 | $327.20 | $245.40 |

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| D7530 | removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue | $153.00 | $122.40 | $91.80 |
| D7540 | removal of reaction producing foreign bodies, musculoskeletal system | $279.00 | $223.20 | $167.40 |
| D7550 | partial ostectomy/sequestrectomy for removal of non-vital bone | $261.00 | $208.80 | $156.60 |
| D7560 | maxillary sinusotomy for removal of tooth fragment or foreign body | $520.00 | $416.00 | $312.00 |
| D7610 | maxilla - open reduction (teeth immobilized, if present) | $3,833.00 | $3,066.40 | $2,299.80 |
| D7620 | maxilla - closed reduction (teeth immobilized, if present) | $3,833.00 | $3,066.40 | $2,299.80 |
| D7630 | mandible - open reduction (teeth immobilized, if present) | $4,811.00 | $3,848.80 | $2,886.60 |
| D7640 | mandible - closed reduction (teeth immobilized, if present) | $2,932.00 | $2,345.60 | $1,759.20 |
| D7650 | malar and/or zygomatic arch - open reduction | $1,125.00 | $900.00 | $675.00 |
| D7660 | malar and/or zygomatic arch - closed reduction | $239.00 | $191.20 | $143.40 |
| D7670 | alveolus - closed reduction, may include stabilization of teeth | $1,007.00 | $805.60 | $604.20 |
| D7671 | alveolus - open reduction, may include stabilization of teeth | $2,903.00 | $2,322.40 | $1,741.80 |
| D7680 | facial bones - complicated reduction with fixation and multiple surgical approaches | $897.00 | $717.60 | $538.20 |
| D7710 | maxilla - open reduction | $297.00 | $237.60 | $178.20 |
| D7720 | maxilla - closed reduction | $619.00 | $495.20 | $371.40 |
| D7730 | mandible - open reduction | $4,042.00 | $3,233.60 | $2,425.20 |
| D7740 | mandible - closed reduction | $1,979.00 | $1,583.20 | $1,187.40 |
| D7750 | malar and/or zygomatic arch - open reduction | $1,214.00 | $971.20 | $728.40 |
| D7760 | malar and/or zygomatic arch - closed reduction | $228.00 | $182.40 | $136.80 |
| D7770 | alveolus - open reduction stabilization of teeth | $170.00 | $136.00 | $102.00 |
| D7771 | alveolus, closed reduction stabilization of teeth | $1,073.00 | $858.40 | $643.80 |
| D7780 | facial bones - complicated reduction with fixation and multiple surgical approaches | $2,621.00 | $2,096.80 | $1,572.60 |
| **Other Repair Procedures** | | | | |
| D7910 | suture of recent small wounds up to 5 cm | $143.00 | $114.40 | $85.80 |
| D7911 | complicated suture - up to 5 cm | $202.00 | $161.60 | $121.20 |
| D7912 | complicated suture - greater than 5 cm | $303.00 | $242.40 | $181.80 |
| D7920 | skin graft (identify defect covered, location and type of graft) | $371.00 | $296.80 | $222.60 |
| D7921 | collection and application of autologous blood concentrate product | $424.00 | $339.20 | $254.40 |
| D7940 | osteoplasty - for orthognathic deformities | $300.00 | $240.00 | $180.00 |
| D7941 | osteotomy - mandibular rami | $5,087.00 | $4,069.60 | $3,052.20 |
| D7943 | osteotomy - mandibular rami with bone graft; includes obtaining the graft | $619.00 | $495.20 | $371.40 |
| D7944 | osteotomy - segmented or subapical | $1,739.00 | $1,391.20 | $1,043.40 |
| D7945 | osteotomy - body of mandible | $1,344.00 | $1,075.20 | $806.40 |
| D7946 | LeFort I (maxilla - total) | $7,093.00 | $5,674.40 | $4,255.80 |
| D7947 | LeFort I (maxilla - segmented) | $5,863.00 | $4,690.40 | $3,517.80 |
| D7948 | LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft | $2,200.00 | $1,760.00 | $1,320.00 |
| D7949 | LeFort II or LeFort III - with bone graft | $595.00 | $476.00 | $357.00 |
| D7950 | osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report | $1,028.00 | $822.40 | $616.80 |
| D7951 | sinus augmentation with bone or bone substitutes via a lateral open approach | $636.00 | $508.80 | $381.60 |
| D7952 | sinus augmentation via a vertical approach | $636.00 | $508.80 | $381.60 |
| D7953 | bone replacement graft for ridge preservation - per site | $212.00 | $169.60 | $127.20 |
| D7955 | repair of maxillofacial soft and/or hard tissue defect | $996.00 | $796.80 | $597.60 |
| D7960 | frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure | $297.00 | $237.60 | $178.20 |
| D7963 | frenuloplasty | $384.00 | $307.20 | $230.40 |
| D7970 | excision of hyperplastic tissue - per arch | $297.00 | $237.60 | $178.20 |

* The maximum allowable fee for each dental procedure agreed to by Delta Dental PPO providers - not applicable to specialists.
** The maximum Delta Dental will pay for each dental procedure – not applicable to specialists.

| Procedure | Description | Maximum* Allowable Charge | Maximum** Reimbursement In Network | Maximum** Reimbursement Out of Network |
|---|---|---|---|---|
| D7971 | excision of pericoronal gingiva | $126.00 | $100.80 | $75.60 |
| D7972 | surgical reduction of fibrous tuberosity | $222.00 | $177.60 | $133.20 |
| D7980 | sialolithotomy | $688.00 | $550.40 | $412.80 |
| D7981 | excision of salivary gland, by report | $383.00 | $306.40 | $229.80 |
| D7982 | sialodochoplasty | $700.00 | $560.00 | $420.00 |
| D7983 | closure of salivary fistula | $312.00 | $249.60 | $187.20 |
| D7990 | emergency tracheotomy | $130.00 | $104.00 | $78.00 |
| D7991 | coronoidectomy | $1,107.00 | $885.60 | $664.20 |
| D7995 | synthetic graft - mandible or facial bones, by report | $1,125.00 | $900.00 | $675.00 |
| D7996 | implant-mandible for augmentation purposes (excluding alveolar ridge), by report | $1,495.00 | $1,196.00 | $897.00 |
| D7997 | appliance removal (not by dentist who placed appliance), includes removal of archbar | $270.00 | $216.00 | $162.00 |
| D7998 | intraoral placement of a fixation device not in conjunction with a fracture | $105.00 | $84.00 | $63.00 |
| D7999 | unspecified oral surgery procedure, by report | $136.00 | $108.80 | $81.60 |
| **ADJUNCTIVE GENERAL SERVICES** | | | | |
| **Unclassified Treatment** | | | | |
| D9110 | palliative (emergency) treatment of dental pain - minor procedure | $57.00 | $45.60 | $34.20 |
| D9120 | fixed partial denture sectioning | $98.00 | $78.40 | $58.80 |
| **Anesthesia** | | | | |
| D9210 | local anesthesia not in conjunction with operative or surgical procedures | $12.00 | $9.60 | $7.20 |
| D9211 | regional block anesthesia | $16.00 | $12.80 | $9.60 |
| D9212 | trigeminal division block anesthesia | $32.00 | $25.60 | $19.20 |
| D9215 | local anesthesia in conjunction with operative or surgical procedures | $25.00 | $20.00 | $15.00 |
| D9219 | evaluation for deep sedation or general anesthesia | $36.00 | $28.80 | $21.60 |
| D9223 | deep sedation/general anesthesia – each 15 minute increment | $98.00 | $78.40 | $58.80 |
| D9243 | intravenous moderate (conscious) sedation/analgesia – each 15 minute increment | $87.00 | $69.60 | $52.20 |
| D9248 | Non-intravenous conscious sedation | $188.00 | $150.40 | $112.80 |
| **Professional Consultation** | | | | |
| D9310 | consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | $64.00 | $51.20 | $38.40 |
| D9430 | office visit for observation (during regularly scheduled hours) - no other services performed | $34.00 | $27.20 | $20.40 |
| D9440 | office visit - after regularly scheduled hours | $76.00 | $60.80 | $45.60 |
| D9630 | other drugs and/or medicaments, by report | $18.00 | $14.40 | $10.80 |
| D9910 | application of desensitizing medicament | $23.00 | $18.40 | $13.80 |
| D9911 | application of desensitizing resin for cervical and/or root surface, per tooth | $24.00 | $19.20 | $14.40 |
| D9930 | treatment of complications (post-surgical) - unusual circumstances, by report | $67.00 | $53.60 | $40.20 |
| D9999 | unspecified adjunctive procedure, by report | $85.00 | $68.00 | $51.00 |

Note 1:
The CDT codes and nomenclature are copyright of the American Dental Association. Notes that appear in italic type are important clarifications of differences between Delta's processing policies and CDT coding. B/R indicates a by-report procedure.

Note 2:
The information listed in this schedule is based on the current fees as of 4/21/2015 and is subject to change. The maximum allowable fees listed apply to dental services obtained in the areas listed above. Fees outside of this area can be different. All services listed are subject to deductibles, maximums, benefit limitations and exclusions.

* The maximum allowable fee for each dental procedure agreed to by Delta Dental PPO providers - not applicable to specialists.
** The maximum Delta Dental will pay for each dental procedure – not applicable to specialists.

**8. Can I go to any dentist?**

Yes, Delta Dental allows enrollees complete freedom of choice when selecting either a general dentist or a specialist.

**9. Is there an orthodontic discount plan available to Orange County Public School employees and their families?**

Yes, contact 407-660-9034 for a list of the orthodontists who are available to you.

**10. What is the Delta Dental Premier network?**

PPO dentist fees usually offer the greatest savings but if you do not visit a PPO dentist, you may benefit by choosing a Delta Dental Premier dentist over a non-Delta Dental dentist. Since Premier dentists agree not to balance bill over Delta Dental's approved amount, your out-of-pocket costs may be lower than with non-Delta Dental Dentists.

# D&P Maximum Waiver®

We'll do **whatever it takes and then some.**

## Preventive care is the key to good oral health

The D&P Maximum Waiver makes it easy for you to save on your out-of-pocket dental costs.

Delta Dental plans have always emphasized diagnostic and preventive benefits, such as coverage for checkups, so that you keep your mouth healthy and need fewer restorative services.

Your plan includes the D&P Maximum Waiver benefit, allowing you to obtain diagnostic and preventive dental services without those costs applying to the plan year maximum. This benefit promotes good oral health and may reduce the need for more expensive, restorative dental services that can result from undetected oral or related health problems.

### Easy to use

The annual maximum is waived for defined diagnostic and preventive services when you visit any licensed dentist. There's nothing for you to keep track of except for your regular checkups. When you need more extensive dental services, there will be more of your annual benefit amount remaining for you to use.

### What services are included?

Diagnostic and preventive dental services may include examinations, x-rays, cleanings and related treatments as defined by your dental plan. Review your Evidence of Coverage booklet for specific coverage details.

**The following sample shows the impact on your annual maximum with and without the D&P Maximum Waiver. Plan benefits and dentist charges vary. Sample assumes two routine checkups and $1,000 annual maximum.**

| | **Without** D&P Maximum Waiver | | | **With** D&P Maximum Waiver | | |
|---|---|---|---|---|---|---|
| Dental treatment | Delta Dental Pays | Enrollee Pays | Maximum Remaining | Delta Dental Pays | Enrollee Pays | Maximum Remaining |
| Diagnostic & Preventive (Exams, x-rays, cleanings): covered at 100% for two visits | $350 | $0 | **$650** | $350 | $0 | **$1,000** |

*Please review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.*

DELTA DENTAL®

**WE KEEP YOU SMILING®**

## Summary of Limitations

**Limitations on Diagnostic and Preventive Benefits:**

a. Delta Dental will pay for routine oral examinations and cleanings (including periodontal cleanings) no more than twice in any 12 month period while the person is an Enrollee under any Delta Dental program or dental care program provided by the Contractholder. Note that periodontal cleanings are covered as a Major Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit.
b. Full-mouth x-rays and panoramic x-rays are limited to once every five (5) years while the person is an Enrollee under any Delta Dental program.
c. Bitewing x-rays are limited to once each 12 months for Primary Enrollees and Dependent Spouse Enrollees and twice in a 12 month period for Dependent Child Enrollees.
d. Topical application of fluoride solutions is limited to Enrollees under age 19.
e. Space maintainers are limited to the initial appliance only and to Enrollees under age 14.
f. Sealants are limited as follows:
   (1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
   (2) Sealants do not include repair or replacement of a sealant on any tooth within two (2) years of its application.

**Limitations on Basic Benefits:**

a. Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same Dentist.
b. Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.
**c.** Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.

**Limitations on Major Benefits:**

a. Delta Dental will not pay to replace any crowns, inlays/onlays or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the Contractholder.
b. Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.
c. Delta Dental limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
d. Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e. the implant supported crown or denture.

**Limitations on All Benefits –** Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called Optional Services. Optional Services also include the use of specialized techniques instead of standard procedures. For example:

a. a crown where a filling would restore the tooth;
b. a precision denture/partial where a standard denture/partial could be used;
c. an inlay/onlay instead of an amalgam restoration; or
d. a composite/resin restoration instead of an amalgam restoration on posterior teeth.

If you receive Optional Services, your Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

***NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN. The dental plan contract must be consulted to determine the exact terms and conditions of coverage. After you enroll, you will receive an Evidence of Coverage which contains a full explanation of benefits, limitations and exclusions.***

# VI. DENTAL INSURANCE

## D. ORTHODONTICS DISCOUNT PROGRAM FOR EMPLOYEES

### ORTHODONTICS

As an employee of Orange County Public Schools, you and your dependents are eligible to receive a 25 percent courtesy discount on orthodontics. There is no monthly premium and it is not necessary to complete any enrollment forms. The participating orthodontist will ask for proper proof of employment with OCPS.

To receive a list of participating orthodontists, please call 407-660-9034.

# VI. DENTAL INSURANCE

## E. VISION DISCOUNT PROGRAM FOR EMPLOYEES

### VISION

As an employee of OCPS, you and your dependents are eligible to receive a courtesy discount on vision care up to 35 percent. This discount does not replace the Humana Specialty Benefits Vision Plan and you don't have to be enrolled in any Delta Dental plan in order to access benefits. There are no monthly premiums and it is not necessary to complete any enrollment forms.

Visit www.eyemedvisioncare.com/deltadental to print an ID card and get a list of participating EyeMed providers or call 1.866.246.9041. When scheduling your appointment, inform the office that you are an EyeMed member with a Delta Dental discount plan. Present your printed ID card at your appointment to receive discounted services.

# VII. VISION INSURANCE

# VII. VISION INSURANCE
## HUMANA SPECIALTY BENEFITS VISION PLAN

If you select the Humana Specialty Benefits Vision Plan, you receive prepaid services for routine eye care - vision exam plus glasses (lenses and frames) or contacts - through a nationwide network, including more than 1,200 eye doctors in Florida. Or you can visit a non-network doctor and be reimbursed according to plan allowances less applicable copayments. Coverage also is available for your spouse/domestic partner and/or eligible children through payroll deductions.

### *PREPAID PLAN BENEFITS*

**Vision Exam:** Your network doctor will do a complete analysis of your eyes and related structures to determine any vision problems or other abnormalities.

**Lenses:** The plan provides the lenses you need for your visual welfare, as determined by your network doctor. Your doctor will order your lenses from an approved optical lab and will verify the accuracy of the finished lenses.

**Frame:** The plan covers a wide range of frames. You can ask your network doctor to show you the frames that the plan covers in full. If you choose a frame that costs more than what the plan covers, you pay the additional charges.

**Contact Lenses:** The plan covers contact lenses, but the extent of coverage depends on whether they are *medically necessary or elective* (i.e., you choose them because you prefer them).

**Medically necessary lenses:** The plan fully covers contact lenses if they are pre-authorized in any of these instances:

- After cataract surgery
- To correct extreme visual acuity problems that cannot be corrected to 20/70 with eyeglasses
- Certain conditions of anisometropia and keratoconus

Your doctor may determine that you need contact lenses due to other conditions. If so, the doctor can ask Humana Specialty Benefits Vision Plan for prior approval. If the Plan approves the request, it will fully cover your contact lenses if you get them from a network doctor.

**Elective lenses:** When you choose contacts instead of glasses, the plan pays a flat benefit of $125 toward the ***combined*** value of your:

- Fitting Fees
- Contact lenses
- Any follow-up visits

The elective contact lens allowance replaces all other benefits. You can choose either the examination, subject to the copayment, and the $125 allowance *or* the other covered services (exam and glasses), but not both.

### *LASIK VISION CORRECTION*

**Reduced fees:** Lasik procedures are available if you are nearsighted or have astigmatism and wear glasses or contacts. We have contracted with many well-known facilities and eye doctors to offer these procedures at substantially reduced fees.

You can take advantage of these low fees when procedures are done by network providers. The network locations listed below offer the following prices (per eye):

| Network Location | Conventional/Traditional | | Custom | |
|---|---|---|---|---|
| **TLC**<br>888-358-3937<br>Designated locations only | **$895** | | **$1,295** | **$1,895*** |
| **Lasik*Plus***<br>866-757-8082 | **$695***<br>Lasik*Plus*<br>Free enhancements<br>for 1 year | **$1,395***<br>Lasik*Plus*<br>Free enhancements<br>for life | **$1,895***<br>Lasik*Plus*<br>Free enhancements<br>for life | |
| **QualSight LASIK**<br>855-456-2020 | **$895**<br>QualSight<br>Free enhancements<br>for 1 year | **$1,295**<br>with QualSight<br>Lifetime Assurance<br>Plan | **$1,320** | **$1,995***<br>with QualSight<br>Lifetime Assurance<br>Plan |

*****with IntraLase™

**You can also use independent Lasik provider network doctors to receive a 10% discount from usual and customary prices and pay no more than $1,800 per eye for Conventional Lasik and $2,300 per eye for Custom Lasik. Your ID card verifies your eligibility for Lasik discounts. You can obtain a list of providers from our website or by calling 866-537-0229.**

***PLAN COPAYMENTS***

| | |
|---|---|
| Vision exam | $5 |
| Lenses and/or frame | $15 |

***FREQUENCY OF BENEFITS***

Plan services and materials are available according to this timetable:

| | |
|---|---|
| Eye exam | Every 12 months |
| Lenses | Every 12 months |
| Frames | Every 12 months |

***DUAL CHOICE***

This is a "dual choice" plan. This means you can choose a network or non-network doctor. How much you pay for covered services and materials depends on whether or not you use a network doctor. Services under the non-network reimbursement schedule are subject to the same timetable and copayments as those for network services. (The copayments do not apply to the elective contact lens allowance.)

This chart shows network and non-network maximum allowances:

| | Network Doctor<br>(up to plan limits, less copayments) | Non-Network Doctor<br>(maximum reimbursement,<br>less copayments) |
|---|---|---|
| **Eye Exam*** | Paid in Full | $ 35 |
| **Standard Plastic Lenses** (per pair) | | |
| Single | Paid in Full | $ 25 |
| Bifocal | Paid in Full | $ 40 |
| Trifocal | Paid in Full | $ 60 |
| Lenticular | Paid in Full | $100 |
| No charge for Polycarbonate lenses for children <19 years of age | | |

**Over 200 different Lens Options are available at a copayment.**

**Examples of some popular options:**

| | | |
|---|---|---|
| **Polycarbonate Lenses**** | $28/$32 | (Shatterproof with a UV coat) |
| **Photochromic/Transitions**** | $77-116 | (Lenses turn darker in sunlight) |
| **Progressives***** | $60-$270 | (Various levels) |

| | | |
|---|---|---|
| **Scratch Resistant**** | $16/$53 | (Anti-Scratch Coating) |
| **UV Protection** | $15 | (Ultra-Violet Protection) |
| **Anti-Reflective Coatings**** | $44-$130 | (Light Reflecting Coating) |

**The above list is not a complete list of lens option benefits. A COMPLETE MEMBER LENS OPTIONS PRICE LIST IS AVAILABLE UPON REQUEST.**

| | | |
|---|---|---|
| **Frame** | $50 wholesale allowance | $ 50 |
| **Contact Lenses** | | |
| Elective (Fitting + lenses)***** | Exam + $125 | Exam + $125 |
| Medically necessary**** | One Pair of contacts paid in full | $210 |

*Complete vision exam per Department of Professional Regulation rule 21Q-3.07.
**Copays shown are based on single/multi-focal lenses.
***Progressive copays shown are a range and vary based on the level.
**** One pair of contact lenses are covered when medically necessary after cataract surgery, or when visual acuity cannot be corrected to 20/70, or due to other medical conditions, prior authorization required.
*****The elective contact lens allowance is paid when a prescription change is warranted, and with the same frequency as eyeglass lenses. The plan pays the contact lens allowance in place of all other benefits.

***HOW TO USE THIS PLAN***

**Network doctor:** Using a network doctor assures quality and cost control, and direct payment to the doctor. When you use a network doctor (as do 97% of all plan members), you'll show your ID card and pay your plan copayments at the time of your visit. You pay nothing more except the cost of any upgrades or cosmetic extras you choose. By using a network doctor you will receive additional value-added extras, such as a 20% discount on a second pair of eyeglasses and/or a 15% discount on professional service fees for elective contact lenses (fittings). These extras are available for 12 months after the covered eye exam from the Humana Specialty Benefits Vision Plan network doctor who performs that initial exam.

**Out-of-state network services:** Humana Specialty Benefits Vision Plan services are available nationwide through a network of thousands of doctors. If you travel, or if a covered family member moves to another state (for example, a child away at college), the plan provides the same benefits as long as that plan member is eligible. You can view providers on Humana's website at www.humanavisioncare.com.

**Non-network doctor:** If you see a non-network doctor, the plan pays non-network benefits in place of services you would have received from a network doctor less applicable copayments. When you use a non-network doctor, you pay that doctor's regular charges at the time of your visit. Then send your itemized receipts with Humana's one page claim form to the plan for reimbursement according to the schedule of benefit allowances on page 2. The actual benefit amount the plan will reimburse you will be the lowest of the maximum shown in the schedule; the amount actually charged; or the amount a doctor usually charges a private patient. You should know that there is no guarantee that scheduled benefit amounts will be enough to fully pay for your eye exam or glasses. Reimbursement benefits are not assignable.

**Dependent–** means any of the following persons:

1) your spouse/domestic partner;
2) your child;
   a) from birth through the end of the calendar year in which the child attains the age of 26;
   b) at least 26 years of age and;
      i. primarily dependent upon you for support because of mental or physical handicap;
      ii. was incapacitated and insured under Policy on his 26th birthday; and
      iii. continues to be incapacitated beyond his 26th birthday.

A child also includes adopted children, children of a domestic partner, as well as stepchildren, children placed in court-ordered custody, including foster children, living with you in a parent-child relationship.

***LIMITATIONS***

**Extra costs:** The plan is designed to cover your visual needs, but not cosmetic choices. If you choose any of the following items there will be extra charges that you must pay. These items include:

- Oversized, coated or faceted lenses
- Blended or progressive lenses
- Tinted or photochromic lenses (except pink #1 and #2)
- A frame that costs more than the plan allowance
- Other cosmetic items

**Not covered:** The plan does not pay benefits for services or materials connected with:

- Orthoptics or vision training
- Subnormal vision aids, aniseikonic lenses or non-prescription (plano) lenses
- Replacing lost or broken lenses and frames you received from the plan (except at the scheduled times when your plan services are otherwise available)
- Medical or surgical eye treatment
- Services or materials provided by Workers' Compensation or any government program
- Any eye exam required by an employer as a condition of employment
- Service or material provided by another group plan with vision benefits
- Two pairs of glasses instead of bifocals

**Coordination of benefits:** This plan will coordinate benefits with other vision coverage you may have (e.g., through your spouse's/domestic partner's employer) so that your benefits from all plans do not exceed 100% of your allowable expenses. The order of benefit determination follows National Association of Insurance Commissioners (NAIC) rules.

***WHEN COVERAGE ENDS***

Your vision coverage ends when you are no longer eligible, or when the plan ends. Benefits end on your last day of coverage, unless you qualify for extended benefits.

**Extension of benefits:** If you're an eligible plan member receiving services and/or benefits on the date your coverage ends, service will continue to completion, but not beyond nine months after the date your coverage ends.

**Continuation of coverage:** You can continue your group coverage to an individual vision policy if you were covered by this plan for at least 3 straight months, and your coverage ends because your employment ends, or a reduction in hours makes you ineligible for the plan. Covered family members may continue coverage if they are no longer eligible because your marriage ends, you die, or a child reaches the age limit or no longer qualifies as a dependent. Coverage may continue through COBRA and/or conversion to an individual policy. Check with the Insurance Benefits Section for details.

# VIII. FLEXIBLE SPENDING ACCOUNTS

**A. MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT**

**B. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

# VIII. FLEXIBLE SPENDING ACCOUNTS

By taking advantage of tax laws, Flexible Spending Accounts (FSAs) work with your benefits to save you money on goods and services that you are already purchasing with after-tax dollars. Almost everyone has a number of necessary, predictable expenses that are not covered by their insurance programs, including, but not limited to health, dental and vision plan co-pays or deductibles and prescriptions. FSAs offer a unique way to help pay for healthcare expenses not covered by your health plan, as well as the expense of dependent care while you are working.

An FSA is one of the only tax advantages available to individuals in any tax bracket.

## *TASC Card*

**Get instant access to your FSA election.**
Once you have elected into the plan, you will automatically receive a TASC Card that is pre-loaded with your annual election for your Medical FSA and/or your Dependent Care FSA. If you are a returning participant, your current card will be loaded with your annual election at the beginning of each plan year.

**What is the advantage of the TASC Card for claims payment?**
The TASC Card is used to conveniently access the available funds in your FSA(s) for eligible purchases.

The TASC Card provides payment convenience for you. At the point of sale, whether you are at a pharmacy or a physician's office, you will have the ability to instantly access your FSA funds by using your TASC Card. This eliminates the process of having to pay for a medical or dependent care expense out-of-pocket and then submit a claim and wait for a check reimbursement. The TASC Card eliminates the "pay and wait" that goes along with paper-based claims processing.

This convenience comes with some stipulations set forth by the Internal Revenue Service (IRS) to maintain favorable tax treatment of your contributions to the plan. You should be aware of the following stipulations:

- The TASC Card will work at qualified medical/dependent care facilities only as well as certain pharmacies and grocery stores. The TASC Card will NOT work at gas stations, restaurants, clothing stores or any other facility that does not normally sell medical/dependent care merchandise.

- The IRS requires FSA administrators (Total Administration Services Corporation) to adjudicate and substantiate any claim that cannot be automatically identified as a valid medical or dependent care expense. This process is performed by TASC requesting a copy of the receipt for any TASC Card transaction that cannot be identified electronically as a valid and qualified expense. For example, TASC may need to request a copy of a receipt from a dentist's office since they cannot identify cosmetic (not a qualified expense) from corrective or preventive services (qualified expenses) when using the TASC Card.

- **<u>You must save all receipts in case you are contacted by TASC to provide more detail about a specific transaction.</u>**

- If you use your TASC Card and are not able to provide a requested receipt, the IRS allows TASC to block your TASC Card for future use until you can either provide a receipt for the transaction in question or you have paid back the plan for the transaction in question.

- If you accidentally use your TASC Card for an ineligible expense, you will be required to re-pay that expense to the plan. If you fail to re-pay the plan, your TASC Card will be blocked and the amount in question will be deducted from any subsequent claim that you submit manually. If for some

reason, you don't submit any manual claims, the IRS allows a 1099 form to be issued to you (i.e. reported as income) in the amount of the expense in question.

**How do you use the TASC Card?**

The TASC Card is a Mastercard debit card and works just like any other bank debit card. The card does NOT have a PIN associated with it, so you need to use the card as if it were a credit card when asked by the merchant. You can request a PIN to access MyCash funds.

**Can my spouse use the TASC Card?**
Once you enroll in the FSA, you will receive a welcome kit from TASC that will include an application for a TASC Card for one additional dependent – spouse or child. This additional TASC card will be supplied at no additional cost to you.
You may request one additional card for a spouse or dependent at no charge; additional cards are $10 each. Simply log in to your online account and click Manage My Card.

***PLAN YEAR***

In order to make your funds available to you as they are deducted from your paycheck. the Plan Year for your FSA(s) is **September 1 through August 31.** Be sure to take this into account when estimating your expenses – only include expenses that you will incur between September 1 and August 31.

**It is necessary to re-enroll in your Medical Expense and/or Dependent Care FSA for each plan year.**

The IRS permits a "grace period" of two months and 15 days following the end of your 2017-18 Plan Year (August 31, 2017) for a Medical Expense FSA. This grace period ends November 15, 2018. During the grace period, you may incur expenses and submit claims. Funds will be automatically deducted from any remaining dollars in your 2017-18 Medical Expense FSA.

You should not confuse the grace period with the plan's "run-out period." The run-out period extends until November 30, 2018. This is a period for filing claims incurred anytime during the 2017-18 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 November 30, 2017. However, the "grace period" mentioned above does not apply to this account. You may not submit reimbursement requests for expenses that occur after August 31, 2018, against the 2017-18 Plan Year.

**Remember that for your 2017-18 FSAs, you have until November 30, 2018, to submit receipts for reimbursement.**

The IRS requires FSA participants to maintain complete documentation, including copies of statements, invoices or bills for reimbursed expenses, for a minimum of one year.

## *WRITTEN CERTIFICATION*

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.

## *A. MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT*

The Medical Expense FSA allows you to use pre-tax dollars to pay for medical expenses not covered under your health plan. With this account, you can pay for your out-of-pocket medical expenses during the plan year for yourself, your spouse, and all eligible dependents. You and your dependents do not have to be enrolled in any other OCPS benefits to take advantage of this program. **The maximum you may place in this account for the plan year is $2,600. The minimum you may place in this account for the plan year is $200.**

**Whose expenses are eligible?**

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

- yourself;
- your spouse;
- your qualifying child; or
- your qualifying relative.

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

- is a tax dependent of the employee meeting the tests of either "qualifying child" or a "qualifying relative";
- is an employee's child that is age 26 (or younger) and will not attain age 27 at the end of the employee's taxable year; the child is not required to be your tax dependent.
- has gross income of less than the exemption found in Section 151(d) of the Internal Revenue Code ($4,050.00 for 2016);
- has a specified family-type relationship to you, is not someone else's qualifying child, and receives more than one-half of his/her 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 receives more than one-half of his/her 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 or both parents can establish a Medical Expense FSA.

**Your medical reimbursement account is pre-funded.** This means that if you have eligible expenses at the beginning of the plan year, you may submit documentation up to your total annual election and be reimbursed **before** the funds are deducted from your paycheck. Funds will continue to be deducted from your paycheck throughout the year. Once you have been reimbursed the total annual election amount, you will not receive further reimbursements for that plan year.

**Examples of Medical Expenses Eligible for Reimbursement***

Acupuncture
Ambulance service
Artificial limbs
Bandages
Birth control pills and devices
Birthing classes/Lamaze-only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
Blood Pressure Monitor
Blood sugar test kits/test strips
Chiropractic therapy/exams/adjustments
Contact lenses (corrective) and contact lens solutions
Co-payments
Crutches (purchased or rented)
Deductibles and co-insurance
Dental Expenses, braces and orthodontic services, cleanings, crowns, deductibles, co-insurance, dental implants, dentures, adhesives and fillings
Diabetic supplies
Diagnostic tests/health screening
Drug addiction/alcoholism treatment
Experimental medical treatment
Eye Exams
Eyeglasses, contacts, or safety glasses, prescription only (warranties are not reimbursable)
Flu shots
Hearing aids, exams and hearing aid batteries (warranties are not reimbursable)
Heating Pad
Incontinence supplies
Infertility treatments
Insulin
Injections and vaccinations
Laser eye surgery; LASIK
Legal sterilization
Medical supplies to treat an injury or illness
Mileage to and from doctor appointments
Nasal strips
Nursing services
Optometrist's or opthalmologist's fees
Over-the-Counter items with a prescription
Physicals
Physical therapy (as a medical treatment)
Physician's fee and hospital services
Pregnancy test
Prenatal vitamins
Prescription drugs and medications
Psychotherapy, psychiatric and psychological service
Reading glasses
Sales tax on eligible expenses
Services connected with donating an organ
Sleep apnea services/products (as prescribed)
Surgery
Transportation for medical care
Wrist supports, elastic wraps
X-ray fees

**For the Disabled:**
**Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile**
**Braille books and magazines in excess of cost of regular editions**
**Note taker, cost of, for a hearing impaired child in school**
**Seeing eye dog (buying, training and maintaining)**
**Special devices, such as a tape recorder or typewriter for a visually impaired person**
**Visual alert system in the home or other items such as a special phone required for a hearing impaired person**
**Wheelchair or autoette (cost of operating/maintaining)**

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

**Medical Expenses Not Eligible for Reimbursement**

- Expenses and treatments for cosmetic purposes
- Vision warranties and service contracts
- Prepayment for medical expenses not yet rendered. Medical services do not have to be paid, but must have been rendered during the plan year, to be eligible for reimbursement.
- Premiums for insurance policies
- Expenses paid by an insurance company: Expenses paid by an insurance company are not eligible for reimbursement – only the portion you have to pay out of your pocket for your medical expenses is eligible for reimbursement.

**Over-the-Counter (OTC) Items**

Over-the-counter items, medicines and drugs are not eligible for reimbursement through a medical FSA unless you have a prescription or letter of medical necessity from a doctor.

You may be reimbursed for OTC items, medicines and drugs through your Medical Expense FSA if:

- the item, 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 item, 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 items, 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 TASC. As soon as an OTC item, medicine or drug becomes eligible under any of the categories below, it will be reimbursable retroactively to the start of the then current plan year.

**Examples of OTC Items Eligible for Reimbursement that will require a letter of medical necessity or prescription for reimbursement:**

Antacids or indigestion relievers, allergy medicine, menstrual pain relief, cough drops, throat lozenges, nasal sinus sprays, nicotine gum or patches, muscle or joint pain cream, first aid cream, calamine lotion, diaper rash ointment, eye drops, hemorrhoid creams and treatments, hydrogen peroxide, motion sickness pills and rubbing alcohol.

**Healthcare expenses requiring additional documentation**
***The following expenses are eligible only when incurred to treat a diagnosed medical condition. Include a letter from your physician along with your request for reimbursement that contains the medical necessity of the expense, the diagnosed condition, the onset of the condition and the physician's signature.***
**Acne treatments and medications**
**Breast Pump**
**Ear plugs**
**Estrovin**
**Eyedrops/Visine**
**Glucosamine**
**Massage treatments**
**Nursing services for care of a special medical ailment**
**Orthopedic inserts or shoes (excess cost of ordinary shoes)**
**Over-the-Counter drugs and medications (effective January 1, 2011)**
**Oxygen equipment and oxygen**
**Propecia/Rogaine (only eligible for a medical condition)**
**Speech therapy**
**Sunscreen or suntan lotion**
**Support hose**
**Varicose vein treatment**
**Veneers**
**Wigs (for mental health condition of individual who loses hair because of a disease)**

**Examples of OTC Items Ineligible for FSA Healthcare:**
Toothpaste, lip moisturizer, face cream, daily vitamins, suntan lotion, etc.

## *B. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT*

The Dependent Care FSA allows you to pay for daycare expenses for your dependents with tax-free dollars **while you (and your spouse) are at work**. 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 they:

- are 13 years old or younger (other than in the case of total disability);
- are a U.S. citizen, national or a resident of the U.S., Mexico, or Canada;
- have a specified family-type relationship to you;
- live in your household for more than half of the taxable year;
- have not provided more than one-half of their own support during the taxable year.

Please note: If you are legally separated or divorced, you can claim reimbursement for Dependent Care expenses only if you are the custodial parent for the greater portion of the calendar year, regardless of which parent is entitled to the dependency exemption on the tax return. For additional guidance on your eligibility to claim Dependent Care expenses, refer to the IRS Publication 503, Child and Dependent Care Expenses. The publication may be accessed at Http:/www.irs.gov/pub/irs-pdf/p503.pdf.

A qualifying individual includes your spouse, if they:

- are physically and/or mentally incapable of self care;
- live 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 they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada;
- are physically and/or mentally incapable of self care;
- are not someone else's qualifying child;
- live 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. For dependent care expenses to be eligible for reimbursement, you must be working during the time your eligible dependents are receiving care. If you are married, your spouse must be either working at the time the daycare services are provided, a full-time student for at least five months during the year or mentally or physically disabled and unable to provide care for him or herself.

The annual maximum contribution to a dependent care account must not exceed $5,000 if you are married filing jointly, or single and file Head of Household. The annual maximum contribution to a dependent care account must not exceed $2,500 if you are married and file Federal tax returns separately. The maximum also must be reduced by the amount your spouse is contributing to a dependent care reimbursement account through his/her employer.

If you participate in a Dependent Care FSA, you cannot take the full dependent tax credit on your income tax return. As a general rule, an employee/couple with a total income of $30,000 or less and only one child will likely realize a greater savings by taking advantage of the tax credit (for the dependent tax credit, the lesser the income, the greater the savings). If you set aside less than the IRS dependent care tax credit, you will be able to deduct the difference between your reimbursement from your Dependent Care FSA and the IRS dependent tax credit.

**Eligible Dependent Care Expenses***

- After school care
- Baby-sitting fees
- Daycare services
- In-home care/au pair services
- Nursery and preschool
- 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.

**Dependent Care Expenses Not Eligible for Reimbursement**

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

**Your dependent care reimbursement account is not pre-funded.** This means that you will only be reimbursed up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the un-reimbursed portion of your claim will be tracked by TASC. You will be automatically reimbursed as additional deductions are taken and deposited into your account, until your entire claim is paid out.

(**NOTE:** Because of the way the deductions are taken and the fact that you must pay the daycare, the first month of this plan creates a negative cash flow. In the subsequent months, the reimbursement from the previous month's deduction can be used to pay the daycare for the current month.)

* 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.

***IRS RULES APPLY***

Consider these points **before** enrolling in either account:

- Before the beginning of each plan year, you designate the amount you wish to contribute to your FSA(s) for the year. Money set aside for health care expenses cannot be used for dependent care or vice versa.
- You may not change your annual contributions unless there is a change in family status, such as marriage, divorce, birth, adoption or death. To submit a change in family status, contact your employer.
- The plan is "use it or lose it." At the end of the grace period, you forfeit any unspent money in your FSA(s).

**IT IS IMPORTANT TO BE CONSERVATIVE IN YOUR ESTIMATES.**

There is a worksheet provided for you at the end of this section to assist you in estimating your eligible annual expenses. **Remember, it is necessary to re-enroll in your Medical Expense and/or Dependent Care FSA for each plan year.** The IRS requires FSA participants to maintain complete documentation, including keeping copies of statements, invoices or bills for reimbursed expenses for a minimum of one year.

- IRS regulations do not allow money to be transferred between FSAs. You cannot transfer unused funds from healthcare to dependent care accounts or vice versa.

***REIMBURSEMENT PROCESS***

You should use your FSA TASC Card wherever it is accepted. If you don't use your TASC Card, you must submit your claims manually.

To obtain a manual reimbursement from your Medical Expense FSA, you can submit a claim online and upload or fax receipts or you can complete your customized claim form and attach itemized documentation that includes

- an 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;
  **or**
- 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 healthcare provider, indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the invoice or bill for the service.

* EOBs are not required if your coverage is through an HMO.

To obtain a manual reimbursement from your Dependent Care FSA, you must complete your customized claim form and attach itemized documentation that includes:

- 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.

Claims forms will be sent to your home address after you enroll in the program. If you do not receive a claim form or have any questions regarding your FSA, please contact TASC at 1-800-422-4661. You may view your FSA balances, check reimbursements status , manage card and update profile and claims history and download a request for reimbursement form at www.tasconline.com.

## FLEXIBLE SPENDING ACCOUNT WORKSHEET

This worksheet will help you determine your annual expenses for your Medical Expense FSA and your Dependent Care FSA**.**

***MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT***

| **Eligible Health Care Expenses** | **Annual Amount** |
|---|---|
| Deductibles, Co-payments for Health Plan | $ _____ |
| Vision Expenses (including Lasik Surgery) | $ _____ |
| Dental Expenses | $ _____ |
| Prescription Copayments | $ _____ |
| Orthodontic Care | $ _____ |
| Lab Fees | $ _____ |
| Other Eligible Expenses | $ _____ |
| **Total Estimated Health Care Expenses for the Plan Year (Max. $2,600)** | **$ _____** |

***DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT***

| **Eligible Health Care Expenses** | **Annual Amount** |
|---|---|
| Child Daycare Expenses | $ _____ |
| Preschool Expenses | $ _____ |
| Summer Day Camp Expenses | $ _____ |
| Adult Daycare Expenses | $ _____ |
| Other Eligible Expenses | $ _____ |
| **Total Estimated Dependent Care Expenses for the Plan Year (Max. $5,000)** | **$ _____** |

# IX. GLOSSARY

# GLOSSARY

**Annual Enrollment** - A specified period of time in which employees may change insurance plans offered by their employer. Annual enrollment occurs once a year.

**Appeal** - A process available to the patient, their family member, treating provider or authorized representative to request reconsideration of a previous adverse determination.

**Balance Billing -** When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider may not balance bill you for covered services.

**Benefits** - Medical services for which your insurance plan will pay, in full or in part.

**Brand-Name Drug** - A drug manufactured by a pharmaceutical company which has chosen to patent the drug's formula and register its brand name.

**Case Management** - Coordination of services to help meet a patient's health care needs, usually when the patient has a condition which requires multiple services from multiple providers. This term is also used to refer to coordination of care during and after a hospital stay.

**Claim -** A claim is a request for payment under the terms of a health benefits plan.

**COBRA (Consolidated Omnibus Budget Reconciliation Act) -** A federal statute that requires most employers to offer to covered employees and covered dependents who would otherwise lose health coverage for reasons specified in the statute, the opportunity to purchase the same health benefits coverage that the employer provides to its remaining employees. This continuation of coverage can only last for a maximum specified period of time.

**Coinsurance** - Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. There are separate coinsurances for in-network and out-of-network services.

**Coordination of Benefits** - A provision in a contract that applies when a person is covered under more than one group health benefits program. It requires that payment of benefits be coordinated by all programs to eliminate overinsurance or duplication of benefits.

**Copayment -** A fixed amount (for example, $20) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

**Coverage** - The benefits that are provided according to the terms of a participant's specific health benefits plan.

**Covered Charges** - Services or benefits for which the health plan makes either partial or full payment.

**Covered Services** - Hospital, medical, and other health care services incurred by the enrollee that are entitled to a payment of benefits under a health benefit contract. The term defines the type and amount of expense that will be considered in the calculation of benefits.

**Date of Service** - The date the service was provided to the participant as specified on the claim.

**Deductible -** A fixed dollar amount you must pay out-of-pocket before the plan begins to pay. Separate limits are applied on a per-person and per-family basis and for in-network and out-of-network services.

**Durable Medical Equipment** - Equipment that can withstand repeated use and is primarily and usually used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

**Effective Date** - The date that insurance coverage begins.

**Elimination Period** - This is the period of time between the date the disability begins and the beginning of the benefit payment period. It is the period during which an employee must be disabled before payment of benefits begins.

**Emergency** - An accident or sudden illness that a person with an average knowledge of medical science believes needs to be treated right away or it could result in loss of life, serious medical complications or permanent disability. Examples of emergency situations include: uncontrolled bleeding, seizure or loss of consciousness, shortness of breath, chest pain or squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, severe burns, broken bones or severe pain.

**Employee Assistance Program (EAP)** - An EAP is an assessment and referral program or a short-term counseling program that is available to employees and their dependents.

**Enrollee** - An individual who is enrolled and eligible for coverage under a health plan contract. Also called Member.

**Enrollment Date** - The term "Enrollment Date" means the first day that Eligible Employees, Retirees, and Dependents are eligible to enroll in the health plan. The Enrollment Date is the first day of the Waiting Period.

**Exclusions** - Specific conditions or services that are not covered under the health plan benefits.

**Explanation of Benefits (EOB)** - A statement provided by the health benefits administrator that explains the benefits provided, the allowable reimbursement amounts, any deductibles, coinsurance or other adjustments taken and the net amount paid.

**Fee Schedule** - A list of amounts to be paid for specific services or procedures by participating providers.

**Flexible Spending Account (FSA)** - An account that reimburses the participant for qualified medical or dependent care expenses through pre-tax savings accounts. At the end of each plan year, unused dollars are forfeited by the participant

**Formulary** - A list of both generic and brand name drugs that are preferred by your health plan. Many prescription drugs produce the same results. Health plans choose formulary drugs that are medically safe and cost effective. A team including pharmacists and physicians meet to review the formulary and make changes as necessary.

**Generic Drug** - A prescription that is not protected by a drug patent. A generic medication is basically a copy of the brand name drug. A generic drug may have a different color or shape than its brand name counterpart, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety. Generics generally cost less than brand name drugs.

**Health Maintenance Organization (HMO)** - A health plan that provides care through contracted physicians and hospitals located in particular geographic or service areas. HMOs emphasize prevention and early detection of illness. Your eligibility to enroll in an HMO is determined by where you live. There are no out-of-network benefits.

**HIPAA (Health Insurance Portability and Accountability Act of 1996)** - The law has several parts: The first part addresses health insurance portability and is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. The law also includes requirements to protect

the privacy of individuals' protected health information. Health plans, providers and other organizations with access to protected health information are covered by the requirements of HIPAA.

**Indemnity Plan** - A type of health benefits plan under which the covered person pays 100% of all covered charges up to an annual deductible. The health benefits plan then pays a percentage of covered charges up to an out-of-pocket maximum.

**In-network** - Describes a provider or health care facility which is part of a health plan's network.

**Limitations** - A restriction on the amount of benefits paid out for a particular covered expense.

**Maintenance Medication** - Medications that are prescribed for long-term treatment of chronic conditions, such as diabetes, high blood pressure or asthma.

**Managed Care** - The coordination of health care services in the attempt to produce high quality health care for the lowest possible cost. Examples are the use of primary care physicians as gatekeepers in HMO plans and pre-certification of care.

**Network** - A group of doctors, hospitals and other providers contracted to provide services to insured individuals for less than their usual fees. Provider networks can cover large geographic markets and/or a wide range of health care services. If a health plan uses a preferred provider network, insured individuals typically pay less for using a network provider.

**Non-Participating Provider/Non-Preferred Providers** - A medical provider who has not contracted with the health plan.

**Occupational Therapy** - Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, and bathing.

**Out-of-Network** - Describes a provider or health care facility which is not part of a health plan's network. If an insured individual has out-of-network benefits, then they usually pay more when using an out-of-network provider.

**Out-of-Pocket Maximum** - The most a plan member will pay per plan year for covered health expenses including copayments, coinsurance and deductibles before the plan pays 100% of covered health expenses for the rest of that plan year. This maximum does not include your premium, balance-billed charges or health care the plan does not cover. Separate limits are applied for medical, pharmacy and mental health/substance abuse maximum amounts and for medical in-network out-of-pocket maximum amounts and medical out-of-network out-of-pocket maximum amounts where applicable.

**Participant** - A person who is eligible to receive health benefits under a health benefits plan. This term may refer to the employee, spouse or other dependents.

**Participating Provider** - A physician, hospital, pharmacy, laboratory or other appropriately licensed facility or provider of health care services or supplies that has entered into an agreement with a health plan to provide services or supplies to a patient enrolled in the plan.

**Physical Therapy** - Rehabilitation concerned with restoration of function and prevention of physical disability following disease, injury or loss of body part.

**Plan Year Deductible** - A fixed dollar amount you must pay out-of-pocket before the plan will begin reimbursing you. Separate limits are applied on a per-person and per-family basis and for in-network and out-of-network services.

**Pre-authorization** - An insurance plan requirement in which you or your primary care physician must notify your insurance company in advance about certain medical procedures (like outpatient surgery) in order for those procedures to be considered a covered expense.

**Precertification** - The process of obtaining certification from the health plan for routine hospital stays or outpatient procedures.

**Pre-existing Condition** - An illness, injury or condition for which the insured individual received medical advice, treatment, services or supplies; had diagnostic tests done or recommended; had medicines prescribed or recommended; or had symptoms of within the 6-month period ending on the Enrollment Date.

**Premiums** - Payments to an insurance company providing coverage.

**Primary Care Physician** - A network physician - a family practitioner, general practitioner, internist or pediatrician (for children) - who is responsible for managing and coordinating your healthcare.

**Provider** - A doctor, hospital, health care practitioner, pharmacy, or health care facility.

**Provider Directory** - Provider directories are listings of providers who have contracted with a health plan to provide care to its participants. Participants refer to the directory to select in-network providers.

**Rehabilitation** - Rehabilitation means the restoration of or improvement in an employee's health and ability to perform the functions of his or her job. It usually involves a program of clinical and vocational services with the goal of returning employees to a satisfying occupation if possible.

**Risk** - Uncertainty of financial loss.

**Service Area** - The geographical area covered by a network of health care providers.

**Specialist** - A physician who practices medicine in a specialty area. Cardiologists, orthopedists, gynecologists and surgeons are all examples of specialists. Under most health plans, family practice physicians, pediatricians and internal medicine physicians are not considered specialists.

**Third Party Administrator (TPA)** - An organization responsible for administering group health plans. This includes collecting premiums, paying claims and providing administrative services.

**Urgent Care** - When prompt medical attention is needed in a non-emergency situation, that's called "urgent" care. Examples of urgent care needs include ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be emergencies.

**Waiting Period** - In order to become eligible for coverage under the policy, a benefited employee must satisfy a certain number of continuous days of service. This is known as the waiting period. In addition, a waiting period can also be the time period between when a disability occurs and when payments from the disability insurance policy begin.