



*For Plan Year
October 1, 2011
to September 30, 2012
Revision #3*

Insurance Benefits

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



2011 - 2012
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

BASIC Plan	A1. CIGNA Open Access Plus BASIC		B1. CIGNA OA Plus In-Network (Network BASIC)	
	Monthly	Biweekly	Monthly	Biweekly
Employee Only	OCPS-Paid		OCPS-Paid	
(+) Children	\$453.28	\$226.64	\$230.36	\$115.18
(+) Spouse	\$644.76	\$322.38	\$382.44	\$191.22
(+) Children (+) Spouse	\$823.38	\$411.69	\$524.40	\$262.20
(+) Half-Family (Husband and wife are OCPS employees covering their dependents and paying this deduction.)	\$94.70	\$47.35	OCPS-Paid	
(+) Part-Time Employee Only*	\$317.00	\$158.50	\$317.00	\$158.50

*For part-time employees, the dependent rate listed above is added to the part-time employee rate.

PREMIUM Plan	A2. CIGNA Open Access Plus PREMIUM		B2. CIGNA Network PREMIUM	
	Monthly	Biweekly	Monthly	Biweekly
Employee Only	\$37.28	\$18.64	\$37.28	\$18.64
(+) Children*	\$505.78	\$252.89	\$257.04	\$128.52
(+) Spouse*	\$719.40	\$359.70	\$426.74	\$213.37
(+) Children (+) Spouse*	\$918.72	\$459.36	\$585.10	\$292.55
(+) Half-Family* (Husband and wife are OCPS employees covering their dependents and paying this deduction.)	\$123.72	\$61.86	OCPS-Paid	
(+) Part-Time Employee Only*	\$317.00	\$158.50	\$317.00	\$158.50

*For employees with dependent coverage and/or part-time employees, the dependent and part-time rates listed above are added to the employee-only rate.

C. Alternatives to Medical Insurance Options

1. Hospital Indemnity Plan - OCPS-Paid 2. 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	At least \$15,000 but less than \$20,000
Class III	\$1.70	\$0.85	At least \$10,000 but less than \$15,000
Class IV	\$1.26	\$0.63	Is less than \$10,000

C. Group Universal Life Insurance - Employee or Spouse

Age	Monthly Payroll Deduction for Each \$10,000	Biweekly Payroll Deduction for Each \$10,000
Under 25	\$ 0.56	\$ 0.28
25-29	\$0.68	\$0.34
30-34	\$ 0.90	\$ 0.45
35-39	\$ 1.02	\$ 0.51
40-44	\$ 1.14	\$ 0.57
45-49	\$ 1.74	\$ 0.87
50-54	\$ 2.58	\$ 1.29
55-59	\$ 4.82	\$ 2.41
60-64	\$ 7.42	\$ 3.71
65-69	\$14.26	\$ 7.13
70-74	\$23.12	\$11.56

Child Term Insurance Rider Available: Biweekly rate for \$5,000 = \$.45 for all eligible dependent children; Biweekly rate for \$10,000 = \$.90 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.

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	\$7.08	\$3.54	\$5.32	\$2.66	\$4.00	\$2.00	\$2.68	\$1.34
\$5,400	\$300	\$10.62	\$5.31	\$7.98	\$3.99	\$6.00	\$3.00	\$4.02	\$2.01
\$7,200	\$400	\$14.16	\$7.08	\$10.64	\$5.32	\$8.00	\$4.00	\$5.36	\$2.68
\$9,000	\$500	\$17.70	\$8.85	\$13.30	\$6.65	\$10.00	\$5.00	\$6.70	\$3.35
\$10,800	\$600	\$21.24	\$10.62	\$15.96	\$7.98	\$12.00	\$6.00	\$8.04	\$4.02
\$12,600	\$700	\$24.78	\$12.39	\$18.62	\$9.31	\$14.00	\$7.00	\$9.38	\$4.69
\$14,400	\$800	\$28.32	\$14.16	\$21.28	\$10.64	\$16.00	\$8.00	\$10.72	\$5.36
\$16,200	\$900	\$31.86	\$15.93	\$23.94	\$11.97	\$18.00	\$9.00	\$12.06	\$6.03
\$18,000	\$1,000	\$35.40	\$17.70	\$26.60	\$13.30	\$20.00	\$10.00	\$13.40	\$6.70
\$19,800	\$1,100	\$38.94	\$19.47	\$29.26	\$14.63	\$22.00	\$11.00	\$14.74	\$7.37
\$21,600	\$1,200	\$42.48	\$21.24	\$31.92	\$15.96	\$24.00	\$12.00	\$16.08	\$8.04
\$23,400	\$1,300	\$46.02	\$23.01	\$34.58	\$17.29	\$26.00	\$13.00	\$17.42	\$8.71
\$25,200	\$1,400	\$49.56	\$24.78	\$37.24	\$18.62	\$28.00	\$14.00	\$18.76	\$9.38
\$27,000	\$1,500	\$53.10	\$26.55	\$39.90	\$19.95	\$30.00	\$15.00	\$20.10	\$10.05
\$28,800	\$1,600	\$56.64	\$28.32	\$42.56	\$21.28	\$32.00	\$16.00	\$21.44	\$10.72
\$30,600	\$1,700	\$60.18	\$30.09	\$45.22	\$22.61	\$34.00	\$17.00	\$22.78	\$11.39
\$32,400	\$1,800	\$63.72	\$31.86	\$47.88	\$23.94	\$36.00	\$18.00	\$24.12	\$12.06
\$34,200	\$1,900	\$67.26	\$33.63	\$50.54	\$25.27	\$38.00	\$19.00	\$25.46	\$12.73
\$36,000	\$2,000	\$70.80	\$35.40	\$53.20	\$26.60	\$40.00	\$20.00	\$26.80	\$13.40
\$37,800	\$2,100	\$74.34	\$37.17	\$55.86	\$27.93	\$42.00	\$21.00	\$28.14	\$14.07
\$39,600	\$2,200	\$77.88	\$38.94	\$58.52	\$29.26	\$44.00	\$22.00	\$29.48	\$14.74
\$41,400	\$2,300	\$81.42	\$40.71	\$61.18	\$30.59	\$46.00	\$23.00	\$30.82	\$15.41
\$43,200	\$2,400	\$84.96	\$42.48	\$63.84	\$31.92	\$48.00	\$24.00	\$32.16	\$16.08
\$45,000	\$2,500	\$88.50	\$44.25	\$66.50	\$33.25	\$50.00	\$25.00	\$33.50	\$16.75
\$46,800	\$2,600	\$92.04	\$46.02	\$69.16	\$34.58	\$52.00	\$26.00	\$34.84	\$17.42
\$48,600	\$2,700	\$95.58	\$47.79	\$71.82	\$35.91	\$54.00	\$27.00	\$36.18	\$18.09
\$50,400	\$2,800	\$99.12	\$49.56	\$74.48	\$37.24	\$56.00	\$28.00	\$37.52	\$18.76
\$52,200	\$2,900	\$102.66	\$51.33	\$77.14	\$38.57	\$58.00	\$29.00	\$38.86	\$19.43
\$54,000	\$3,000	\$106.20	\$53.10	\$79.80	\$39.90	\$60.00	\$30.00	\$40.20	\$20.10
\$55,800	\$3,100	\$109.74	\$54.87	\$82.46	\$41.23	\$62.00	\$31.00	\$41.54	\$20.77
\$57,600	\$3,200	\$113.28	\$56.64	\$85.12	\$42.56	\$64.00	\$32.00	\$42.88	\$21.44
\$59,400	\$3,300	\$116.82	\$58.41	\$87.78	\$43.89	\$66.00	\$33.00	\$44.22	\$22.11
\$61,200	\$3,400	\$120.36	\$60.18	\$90.44	\$45.22	\$68.00	\$34.00	\$45.56	\$22.78
\$63,000	\$3,500	\$123.90	\$61.95	\$93.10	\$46.55	\$70.00	\$35.00	\$46.90	\$23.45
\$64,800	\$3,600	\$127.44	\$63.72	\$95.76	\$47.88	\$72.00	\$36.00	\$48.24	\$24.12
\$66,600	\$3,700	\$130.98	\$65.49	\$98.42	\$49.21	\$74.00	\$37.00	\$49.58	\$24.79
\$68,400	\$3,800	\$134.52	\$67.26	\$101.08	\$50.54	\$76.00	\$38.00	\$50.92	\$25.46
\$70,200	\$3,900	\$138.06	\$69.03	\$103.74	\$51.87	\$78.00	\$39.00	\$52.26	\$26.13
\$72,000	\$4,000	\$141.60	\$70.80	\$106.40	\$53.20	\$80.00	\$40.00	\$53.60	\$26.80
\$81,000	\$4,500	\$159.30	\$79.65	\$119.70	\$59.85	\$90.00	\$45.00	\$60.30	\$30.15
\$90,000	\$5,000	\$177.00	\$88.50	\$133.00	\$66.50	\$100.00	\$50.00	\$67.00	\$33.50
\$99,000	\$5,500	\$194.70	\$97.35	\$146.30	\$73.15	\$110.00	\$55.00	\$73.70	\$36.85
\$108,000	\$6,000	\$212.40	\$106.20	\$159.60	\$79.80	\$120.00	\$60.00	\$80.40	\$40.20
\$117,000	\$6,500	\$230.10	\$115.05	\$172.90	\$86.45	\$130.00	\$65.00	\$87.10	\$43.55
\$126,000	\$7,000	\$247.80	\$123.90	\$186.20	\$93.10	\$140.00	\$70.00	\$93.80	\$46.90
\$135,000	\$7,500	\$265.50	\$132.75	\$199.50	\$99.75	\$150.00	\$75.00	\$100.50	\$50.25

DENTAL INSURANCE

	A. DeltaCare®USA Managed Dental Plans				B. DeltaDental PPO Dental Plan	
	Basic		Comprehensive			
	Monthly	Biweekly	Monthly	Biweekly	Monthly	Biweekly
Employee Only	\$9.16	\$4.58	\$14.98	\$7.49	\$39.20	\$19.60
Employee + 1 Dependent	\$15.14	\$7.57	\$28.02	\$14.01	\$67.30	\$33.65
Employee + 2 or More Dependents	\$22.38	\$11.19	\$34.32	\$17.16	\$96.26	\$48.13

VISION INSURANCE

	Vision Care Plan	
	Monthly	Biweekly
Employee Only	\$6.22	\$3.11
Employee + Dependents	\$17.22	\$8.61

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I. GENERAL INSURANCE INFORMATION

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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 63 days, with coverage to be effective on the first day of the following month.

In order to have any coverage, all eligible new employees must complete the appropriate paperwork.

Dependents

The following definition of dependents applies to the medical plan. Dependent children eligibility will vary by type of coverage (i.e. dental, vision, life). Review specific plan details for more information.

1. Spouse (as defined under Federal Law)
2. A child of the covered Employee or the covered Employee's spouse who is under the age of 19. 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 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. Grandchild of a dependent other than spouse. 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 guardianship.
3. A child may be covered through the end of the calendar year in which the child attains the age of 26.
4. An adult child covered in 3. 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 retardation 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.

ENROLLING FOR COVERAGE

Initial Enrollment

The initial enrollment period begins when employees hired in an eligible payroll area meet all eligibility requirements. The Insurance Benefits Office must receive your completed insurance paperwork prior to your effective date.

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 notify OCPS Insurance Benefits Office in writing of your desire to terminate or make changes. OCPS typically holds Annual Enrollment in 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, must remain enrolled 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. Generally changes must be submitted in writing to 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 written notice is provided to 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 written 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.

CREDITABLE COVERAGE

You will not be covered for pre-existing conditions for the first 12 months of coverage in any medical plan. Pre-existing condition exclusions do **not** apply to pregnancy or to employees or dependents under age nineteen (19). Credit for previous coverage will be given to employees and dependents who had a group, individual, public, or other health plan coverage and did not have a break in coverage of more than 63 days prior to their enrollment date. All questions about the pre-existing condition exclusions and creditable coverage should be directed to their prior health plan. Please refer to Section C. Frequently Called Phone Numbers for telephone listings for the medical plans.

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). 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

*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).

CALENDAR YEAR

January 1 through December 31 of each 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). If you do not pay the premiums due, you must re-qualify for the insurance when you return to work, subject to the following new employee provisions:

1. After a waiting period of a minimum of 63 days, you will be covered on the first day of the following month.
2. You will not be covered for pre-existing conditions for the first 12 months of coverage in the (PPO Type) and (HMO Type) plans. Pre-existing condition exclusions do **not** apply to pregnancy or to employees or dependents under age nineteen (19). Credit for previous coverage will be given to employees and dependents who had a

group, individual or governmental health plan and did not have a break in coverage of more than 63 days prior to their returning from leave date.

3. If you work less than 17.5 hours per week, you will not receive coverage. If you work at least 17.5 hours per week, but less than 25 hours per week, you will receive a Board contribution of 50 percent of the Employee only medical insurance rate. If you work 25 or more hours per week, you will have 100 percent of the Employee only medical insurance rate paid by OCPS.

*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.

To be eligible, an employee must be employed by OCPS for 12 months with at minimum 1,250 hours 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 407.317.3406.

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.

DEFINITIONS

Deductible - The amount of allowable out-of-pocket expenses that must be met by you before any costs will be payable by the insurance provider.

Copayment - The flat dollar amount that you must pay each time you use the benefit.

Coinsurance - You and your plan share in the covered expenses. The plan will pay the specified percent of allowable charges and you are responsible for the balance of the payment.

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.

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 or any other reason prohibited by law. The Equal Employment Opportunity (EEO) Supervisor responsible for compliance is Carianne Reggio. Compliance matters relating to Section 504 and Title IX should also be submitted through Carianne Reggio at the Educational Leadership Center, 445 W. Amelia Street, Orlando, Florida 32801. (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 and/or your eligible children.

CIGNA Open Access Plus BASIC & Open Access Plus PREMIUM

With these plans, 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.

CIGNA OA Plus In-Network (Network BASIC) & Network PREMIUM

When using these plans, you can go to any provider within the network to identify, evaluate and help manage all your healthcare needs. You must select a Primary Care Physician (PCP) and referrals from your PCP are required to see a Specialist (unless otherwise noted).

Alternatives

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 may select one of the two OCPS paid alternatives:

1. Hospital Indemnity Plan, including prescription coverage and additional term life insurance; or
2. 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, 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 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 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).

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 the 2011-2012 open enrollment or if you are a new employee enrolling during your initial enrollment period.

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. You will be reimbursed for a portion of your bill. The enclosed schedule of benefits shows the maximum amount that you will be reimbursed for each procedure. **With this plan the maximum benefit each year is \$1,250.** 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.

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. 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.

C. FREQUENTLY CALLED PHONE NUMBERS

CIGNA (For All CIGNA Medical Plans)	1.800.244.6224
Total Administration Services Corporation (TASC)	1.800.422.4661
DeltaCare® USA Managed Dental Plans	1.800.422.4234
Delta Dental PPO (Preferred Provider Organization) Dental Plan	1.800.616.3629
Employee Assistance Program	407.317.3535
Employee Wellness Program	407.317.3200, Ext. 2929
Express Scripts, Inc.	1.877.493.1954
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

D. WEBSITES (FOR PROVIDER DIRECTORIES)

CIGNA Open Access Plus BASIC
CIGNA Open Access Plus PREMIUM
CIGNA OA Plus In-Network/Network BASIC

www.cigna.com

Choose “**Provider Directory**.” Select the Type of Provider, enter your zip code or city/state. Click on “Next”, then choose “**Open Access Plus, OA Plus, Choice Fund OA Plus**.” Click on “Search”.

CIGNA Network PREMIUM

www.cigna.com

Choose “**Provider Directory**.” Select the Type of Provider, enter your zip code or city/state. Click on “Next”, then choose “**Network, HMO, POS**.” Select Healthplan Network “**FL-Orlando**.” Click on “Search”.

Total Administration Services Corporation
(TASC)

www.tasconline.com

DeltaCare® USA Managed Dental Plans

www.deltadentalins.com

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

Under **Find a Dentist**, select your plan network, **Delta Dental PPO**. Select your state, then your city or zip code.

Express Scripts, Inc.

www.express-scripts.com

Humana Specialty Benefits Vision Plan

www.compbenefits.com

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.

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 Change Form and mark the after tax box 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), 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 and return a Section 125 Plan election form 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.

(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

- 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 an employee has 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 an employee loses coverage due to the elimination of an existing benefits package option or exceeds the overall lifetime or annual benefit maximum, 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 an employee’s 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 an employee’s spouse and/or dependent loses coverage due to the elimination of an existing benefits package option (with no similar coverage available) or exceeds the overall lifetime or annual benefit maximum, 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, but not earlier than the first pay period beginning after the election form is completed and returned to OCPS. The revocation and new benefit election must be consistent with the respective insurance benefit plan limitations and requirements.
 - j. You are required to complete a Request For Status Change Form, which requires documented proof of the status change. Return it to the Insurance Benefits Office 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. How will the Section 125 Plan affect my social security and retirement benefits?
- 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. How do I claim my rights under the Section 125 Plan?
- 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.**

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.

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 18-month 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

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 contraindicated 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 your 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.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

Florida, for example, has a program called "Medicaid Reform" that is only currently available in five counties (Broward, Baker, Clay, Duval and Nassau). Medicaid Reform allows a Medicaid individual to opt-out of Medicaid and use the Medicaid premiums to purchase employer-sponsored insurance.

If you think you might be eligible for Medicaid Reform in Florida, please review the "Florida Medicaid Summary of Services 09/10" booklet located at the following website:

http://www.fdhc.state.fl.us/Medicaid/pdffiles/SS_10_100105_SOS.pdf

The discussion on Medicaid Reform starts on page 39 (Section IV).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

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 January 22, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1.800.362.1504	Website: http://www.dhcs.ca.gov/Pages/default.aspx Phone: 1.800.635.2570
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid Phone (Outside of Anchorage): 1.888.318.8890 Phone (Anchorage): 907.269.6529	Medicaid Website: http://www.colorado.gov Medicaid Phone: 1.800.866.3513 CHIP Website: http://www.CHPplus.org CHIP Phone: 303.866.3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 602.417.5422	
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1.888.474.8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1.866.762.2237
GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1.800.869.1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1.800.694.3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 208.334.5747 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1.800.926.2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1.877.255.3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1.877.438.4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1.800.992.0900
IOWA – Medicaid	CHIP Website: http://www.nevadacheckup.nv.org/
Website: www.dhs.state.ia.us/hipp/ Phone: 1.888.346.9562	CHIP Phone: 1.877.543.7669

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov Phone: 1.800.635.2570	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAID/PROGRAM/default.htm Phone: 1.800.852.3345 x 5254
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1.800.635.2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
LOUISIANA – Medicaid	Medicaid Phone: 1.800.356.1561
Website: www.dhh.louisiana.gov/offices/?ID=92 Phone: 1.888.342.0555	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1.800.701.0710
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1.800.321.5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1.888.997.2583
MASSACHUSETTS – Medicaid and CHIP	CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1.888.997.2583
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1.800.462.1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800.657.3739	Website: http://www.nyhealth.gov/health_care/medicaid Phone: 1.800.541.2831
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573.751.6944	Website: http://www.nc.gov Phone: 919.855.4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1.800.755.2604	Website: http://health.utah.gov/medicaid/ Phone: 1.866.435.7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1.888.365.3742	Website: http://ovha.vermont.gov/ Telephone: 1.800.250.8427

OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml	Medicaid Website: http://www.famis.org/
Medicaid Phone: 1.800.359.9517	Medicaid Phone: 1.800.432.5924
CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml	CHIP Website: http://www.famis.org/
CHIP Phone: 1.800.359.9517	CHIP Phone: 1.866.873.2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicaidassistance/doingbusiness/003670053.htm	Website: http://ihrsa/sites/DCS/COB/default.aspx
Phone: 1.800.644.7730	Phone: 1.800.562.6136
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov	Website: http://www.wvrecovery.com/hipp.htm
Phone: 401.462.5300	Phone: 304.342.1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm
Phone: 1.888.549.0820	Phone: 1.800.362.3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/	Website: http://www.health.wyo.gov/healthcarefin/index.html
Phone: 1.800.440.0493	Telephone: 307.777.7531

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can 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, Ext. 61565

GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on your Enrollment Date. The pre-existing condition exclusion does not apply to pregnancy or to employees or dependents under age nineteen (19).

The pre-existing condition exclusion extends for twelve (12) months. The twelve (12) month exclusion for individuals enrolled during the Initial Enrollment Period begins on the Enrollment Date. The twelve (12) month exclusion for individuals enrolled during the Special Enrollment Period begins on the Effective Date. However, you can reduce the length of this exclusion period by the number of days of your prior “creditable coverage.” Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage 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.

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 in 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 and dental 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 Pre-Existing Condition Limitation (PCL) or 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.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

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

Recent updates to the Health Insurance Portability and Accountability Act (HIPAA) require 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 equivalent to the medical plan.

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 and is being renewed for the subsequent 2011-2012 plan year beginning October 1, 2011 and ending September 30, 2012. 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.

Patient Protection under Healthcare Reform

The CIGNA OA Plus In-Network/Network BASIC and CIGNA Network PREMIUM plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, CIGNA designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CIGNA at 1.800.244.6224. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from CIGNA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact CIGNA at 1.800.244.6224.

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:

Ronald Blocker, 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

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121
1.877.493.1954

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 Wachovia Bank N.A. of Jacksonville. Investment instruments may be made through other institutions as appropriate. Name, title, and principal place of business for the Trustees of the Trust are as follows:

Ronald Blocker, Superintendent
Orange County Public Schools
P. O. Box 271
Orlando, FL 32802

Dr. Henry Boekhoff, Consultant
Mixon & Associates
119 E. Park Avenue
Tallahassee, FL 32301

Becky Cherney
Florida Health Care Coalition
4401 Vineland Rd., Suite A-10
Orlando, FL 32811

Richard Collins, Chief Financial Officer
Orange County Public Schools
P.O. Box 271
Orlando, FL 32802

Emma Newton
7174 Harbor Heights Circle
Orlando, FL 32835

ORANGE COUNTY PUBLIC SCHOOLS
INSURANCE ENROLLMENT/CHANGE FORM

____ New Employee ____ Change

____ Adoption	____ Newborn
____ Family	____ Marriage
____ Status Change	____ Beneficiary

Please Print

OFFICE USE ONLY:			
POS. HRS.	SALARY	EMPLOYMENT DATE	EFFECTIVE DATE
MONTH OF DED.	DATE PROCESSED	INITIALS	LEAVE OF ABSENCE
PAYROLL AREA	EMPLOYEE I.D.#	ADJ. AMOUNT	
CERTIFICATE OF CREDIBLE COVERAGE: <input type="checkbox"/> YES <input type="checkbox"/> NO		DROP DATE	

____ Employee Last Name	____ First Name	____ MI	____ Social Security #	____ Date of Birth
____ Mailing Address		____ City	____ State	____ Zip
____ Home Phone #	____ Work Phone #	____ Work Location Name		____ Position Title

I. GENERAL INFORMATION - If you want to ADD or DROP an option listed on this form, please check the appropriate box for the coverage you want to add or drop. If you want to **CHANGE** a medical, dental or vision insurance option, please check the add box for the coverage you want to add, and the drop box for the coverage you want to drop. **All payroll deductions, except for the dependent life, universal life, and disability will be taken BEFORE tax, unless you indicate you want after-tax deductions by checking the After-Tax box below.**

☐ After Tax

II. MEDICAL INSURANCE

Please Select One:

Complete OCPS Medical Enrollment Form

	ADD		DROP	
	A1. CIGNA Open Access Plus BASIC	B1. CIGNA Network BASIC Plan	CIGNA Open Access Plus BASIC	CIGNA Network BASIC Plan
1. Employee Only (no employee contribution required).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Employee + Children.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Employee + Spouse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Employee + Children + Spouse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Half Family - Both husband & wife are OCPS employees covering their dependents.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse's Name _____ SS # _____				
6. Part-Time Employee Only- (employee contribution required) (Please complete D.1 below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADD

DROP

Please Select One:

Complete OCPS Medical Enrollment Form

	ADD		DROP	
	A2. CIGNA Open Access Plus PREMIUM	B2. CIGNA Network PREMIUM Plan	CIGNA Open Access Plus PREMIUM	CIGNA Network PREMIUM Plan
1. Employee Only (employee contribution required).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Employee + Children.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Employee + Spouse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Employee + Children + Spouse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Half Family - Both husband & wife are OCPS employees covering their dependents.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse's Name _____ SS # _____				
6. Part-Time Employee Only- (employee contribution required) (Please complete D.1 below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Alternatives to Medical Insurance Options

If you are already covered by group medical coverage (ex. your spouse's medical plan), you can select one of the following alternatives **instead** of the options listed above. (No employee contribution is required for full or part-time employees.)

Other Group Medical Insurance Company _____

1. Hospital Indemnity Plan (HIP) - **Complete Medical Enrollment Form**.....

2. Disability/Vision Plan - **Complete Enrollment Form**.....

I also am enrolling my family in the Vision Care Plan (no employee contribution required)

HIP/Life Beneficiary _____

ADD

DROP

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

D. Acceptance/Waiver of Medical Insurance Benefits for Part-Time Employees

Medical insurance benefits offered by Orange County Public Schools have been explained to me, and as a part-time employee who works between 17.5 and 24.9 hours per week, I understand that I will be responsible for part of the monthly cost (see Rate Sheet).

Please Select One:

- ☐ 1. I have decided to accept this insurance (please complete II.A1., II.B1., II.A2. II.B2., or II.C above).
- ☐ 2. I have decided to decline this insurance.

Initials _____

III. TERM LIFE INSURANCE

A. OCPS Paid Life Insurance (Complete Beneficiary Information on Page 2)

Equal to one times annual salary (no employee contribution required)

B. Dependent Life Insurance.....

Spouse and/or Child(ren)

IV. GROUP UNIVERSAL LIFE (GUL)

You may purchase additional life insurance coverage for yourself, your spouse, and your eligible dependent children. You and your spouse also have the ability to make contributions to a Cash Accumulation Fund. Please complete the Group Universal Life Insurance Enrollment Form.

V. DISABILITY INSURANCE

Disability Plan – Complete Disability Enrollment Form.....

Monthly Benefit \$

Circle Waiting Period: 14 day 30 day 60 day 180 day

VI. DENTAL INSURANCE

Select ONE of these plans:

* CHOOSE A DENTAL OFFICE #

Please select one:

1. Employee only.....

2. Employee + 1 dependent.....

3. Employee + 2 or more dependents.....

DeltaCare USA

*Basic OR- *Comprehensive

Delta Dental PPO

PPO

Drop

** Complete the following dependent information for DENTAL coverage only.

Name

Relationship

Sex

Date of Birth

VII. VISION INSURANCE

Humana Specialty Benefits Vision Plan

Please select one:

1. Employee Only

2. Employee + Dependents

Add

Drop

** Complete the following dependent information for VISION coverage only

Name

Relationship

Sex

Date of Birth

VIII. FLEXIBLE SPENDING ACCOUNTS (Min. \$200; Max. \$5,000 per plan year [Sept. – Aug.])

Medical Expense Flexible Spending Account Plan Year Amount \$

Dependent Care Flexible Spending Account Plan Year Amount \$

Note: Enter whole dollar amounts only

IX. BENEFICIARY INFORMATION

The following beneficiary information will pertain to all beneficiary relevant plans with the exception of the Group Universal Life.

Please complete the form in the GUL packet or call Minnesota Life at 1.800.843.8358 to designate or change a beneficiary for GUL.

Please complete the following information:

Complete Name

Relationship

Beneficiary: Primary

Contingent

I have received the enrollment highlights explaining my eligibility for certain voluntary coverages available under my group insurance program. After careful thought and understanding, I have decided on the above elections from among the voluntary coverages for which I am eligible. I understand that proof of good health satisfactory for the approved plans may be required if: 1. I decide to enroll for any coverage 31 days after eligibility for insurance; 2. certain participation requirements for the plan(s) are not met; or 3. the benefit amount exceeds the specified limit for which proof of good health applies; I understand that such proof will be at my own expense. I understand that these elections are irrevocable for the plan year. Unless I have a valid change in family status, I understand that I will continue to have my before-tax payments taken throughout the plan year. None of the monies from these payments will be added back into my check if I discontinue coverage. If I have indicated payment for the above elections is to be made as an after-tax deduction, I hereby authorize my employer to deduct from my salary and pay to the School Board the premiums due for the approved insurance plan(s) for which I am enrolling. This after-tax deduction means that there is no salary reduction. These authorized deductions may be made at intervals mutually agreed upon by my employer and the company, and are to be paid to the appropriate company when due. Maximum life insurance, including OCPS Paid Life, is limited to a maximum of \$50,000 under payroll reduction (before tax). I hereby authorize to release any information that is necessary in the administration of the insurance programs I have selected.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of obtaining a benefit that the employee, spouse and/or dependent would not otherwise be entitled. In signing this form you (OCPS employee) confirm that the information contained herein (including dependent information) is accurate to the best of your knowledge. Further you acknowledge that it is your responsibility to notify the Plan of any changes to dependent (spouse and /or children) eligibility. Should you knowingly provide false, incomplete or misleading information OCPS will refer you to Employee Relations, seek recovery of all applicable premiums and paid claims and report you to the appropriate agencies. As the Plan Administrator of the OCPS Benefits Trust, we are required by the Secretary of the US Dept. of Health & Human Services to comply with the Mandatory Reporting Law (Section III of Public Law 110-173) to collect and report to the Secretary the Social Security Number and Medicare Number of all plan members (employee, spouse, dependents) for purposes of the coordination of health benefits.

EMPLOYEE SIGNATURE

DATE SIGNED

II. MEDICAL INSURANCE

A. CIGNA Open Access Plus BASIC & PREMIUM

II. MEDICAL INSURANCE

A. CIGNA HealthCare Open Access Plus BASIC & PREMIUM

OVERVIEW

CIGNA HealthCare Open Access Plus 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: Provider Directory, then Open Access Plus ONLY)

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.

CIGNA HealthCare Open Access Plus 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.

SCHEDULE OF BENEFITS - Open Access Plus BASIC

NOTE: Deductibles must first be met unless otherwise indicated.

BENEFIT FEATURE	IN-NETWORK		OUT-OF-NETWORK	
CALENDAR YEAR DEDUCTIBLE: A covered person has two separate deductibles: In-Network and Out-of-Network. The deductible amounts are maximums. Deductible amounts met in October, November and December apply toward the current year and the following year.				
Income to \$10,000	INDIVIDUAL \$600	FAMILY** \$1,200	INDIVIDUAL \$700	FAMILY** \$1,400
\$10,001 - \$20,000	\$725	\$1,450	\$850	\$1,700
\$20,001 - \$40,000	\$750	\$1,500	\$900	\$1,800
Over \$40,000	\$900	\$1,800	\$1,100	\$2,200
Maximum Out-of-Pocket Expense (Each calendar year, including copayments, not including deductible)	Calendar Year Out of Pocket Maximums: A covered person has two separate Out-of-Pocket Maximums: In-Network and Out-of-Network.			
Income to \$10,000	\$5,700	\$11,400	\$7,200	\$14,400
\$10,001 - \$20,000	\$6,450	\$12,900	\$8,700	\$17,400
\$20,001 - \$40,000	\$7,200	\$14,400	\$10,200	\$20,400
Over \$40,000	\$7,950	\$15,900	\$11,700	\$23,400
Your Coinsurance	30% unless otherwise indicated		50% unless otherwise indicated	
Maximum Benefit – Lifetime			Unlimited	
COVERED SERVICES (after deductible is met, unless otherwise indicated)				
NOTE: All of the following services may be subject to review for medical necessity.				
HOSPITAL SERVICES	Semi-Private Room Limit			
Inpatient Expenses*	70% coverage		50% coverage	
Outpatient Expenses*	70% coverage		50% coverage	
EMERGENCY CARE SERVICES				
Illness or Accidental Injury (Within 90 days of Injury) Not Resulting in Hospital Admission	\$300 copay & 70% coverage		\$300 copay & 50% coverage	
Life-threatening Illness Resulting in Hospital Admission	70% coverage		50% coverage	
Urgent Care	70% coverage		50% coverage	

BENEFIT FEATURE	IN-NETWORK		OUT-OF-NETWORK
PROFESSIONAL SERVICES Office Visits	<u>PCP#</u> \$20 copay	<u>Specialist</u> \$35 copay	50% coverage
PROFESSIONAL SERVICES Well Child Services (Covered charges) **** Routine Preventive Care (including OB/Gyn Preventive Care, limited to one visit per year) Adult Immunizations (as recommended by CDC)***** Allergy Injections***** Maternity Services* Surgery Inpatient Outpatient In-Hospital Visits Diagnostic Services* Outpatient or Inpatient Setting Independent Lab Physician Office Advanced Radiological Imaging (ex: MRA, MRI, CT, PET) (any setting) Ambulance Anesthesiology Second Opinion	100% coverage, deductible waived (From birth to age 16) (according to Health Care Reform Act Preventive Care Guidelines Δ) 100% coverage, deductible waived (Age 17 and above) (according to Health Care Reform Act Preventive Care Guidelines Δ) 100% coverage, deductible waived (according to Health Care Reform Act Preventive Care Guidelines Δ) <u>PCP#</u> <u>Specialist</u> \$20 copay \$35 copay (or cost, whichever is less) 70% coverage 70% coverage 70% coverage 70% coverage 70% coverage 70% coverage <u>PCP#</u> <u>Specialist</u> \$20 copay \$35 copay \$100 copay & 70% coverage 70% coverage 70% coverage \$35 Specialist copay		50% coverage, deductible waived (From birth to age 16) Not covered Not covered 50% coverage 50% coverage 50% coverage 50% coverage 50% coverage 50% coverage \$100 copay & 50% coverage 50% coverage 50% coverage 50% coverage
SPECIFIED THERAPIES* To include Physical, Occupational, Speech, Cardiac, Spinal Manipulation (Chiropractic Therapy). Limited to 50 days combined maximum per calendar year.	\$25 per office visit copay		50% coverage

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
MISCELLANEOUS SERVICES		
Home Health Care* (100 days maximum per calendar year)	70% coverage	50% coverage
Skilled Nursing Facility and Rehabilitation Facility* (120 days combined maximum per calendar year)	70% coverage	50% coverage
Durable Medical Equipment* External Prosthetic Appliance	70% coverage 70% coverage	50% coverage 50% coverage
HOSPICE SERVICES		
Inpatient Services	70% coverage	50% coverage
Outpatient Services	70% coverage	50% coverage
DENTAL SERVICES		
Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth, as well as hospitalization charges due to a medical condition necessitating a hospital setting		
Accidental Injury to Sound Teeth (Professional services and hospitalization)	70% coverage	50% coverage
Removal of Impacted Teeth When Hospitalization Required * (Hospital charges only)	70% coverage	50% coverage
Temporomandibular Joint Dysfunction (TMJ) *(Surgical charges only)	70% coverage	50% coverage
TRANSPLANTS * Includes all medically appropriate, non- experimental transplants		
Inpatient Facility	100% at a LifeSource Center deductible waived, otherwise 70%	50% coverage
Physician Services	100% at a LifeSource Center deductible waived, otherwise 70%	50% coverage

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS ***	<p>Participating Retail Pharmacy – Up to a 30-day supply for non-maintenance medications at retail \$7 copay generic</p> <p>◆20% coinsurance/minimum \$30 copay brand name in formulary</p> <p>◆50% coinsurance/minimum \$60 copay brand name not in formulary</p> <p>◆20% coinsurance/minimum \$75 copay medications more than \$1,500</p> <p><i>Maintenance drugs must be filled using one of the following two options:</i></p> <p><u>Option 1 (Preferred):</u> Express Scripts Home Delivery – 2 copays for 90-day supply of maintenance medications \$14 copay generic</p> <p>◆20% coinsurance/minimum \$60 copay brand name in formulary</p> <p>◆50% coinsurance/minimum \$120 copay brand name not in formulary</p> <p>◆20% coinsurance/minimum \$150 copay medications more than \$1,500</p> <p><u>Option 2:</u> 90 Day Retail Program – 3 copays for 90-day supply of maintenance medications at selected retail pharmacies \$21 copay generic</p> <p>◆20% coinsurance/minimum \$90 copay brand name in formulary</p> <p>◆50% coinsurance/minimum \$180 copay brand name not in formulary</p> <p>◆20% coinsurance/minimum \$225 copay medications more than \$1,500</p> <p><i>Please note that on the fourth fill of a maintenance medication for a 30-day supply at retail, the copay is 100% of the Express Scripts discounted cost of the medication.</i></p>	<p>Coinsurance or copayment plus the difference in cost between out-of-network and network cost to the plan</p>
<p>◆(1) Member pays coinsurance percentage or copayment, whichever is greater; (2) Percentage based on the discounted cost of the drug; (3) \$300 copayment maximum for a 30-day supply.</p>		

Δ	http://www.healthcare.gov/law/about/provisions/services/lists.html
*	Service may require precertification and/or prior authorization. <u>Non-compliance can result in a PENALTY UP TO \$500.</u> (See handbook for detailed explanation.)
**	In situations of half-family (when married employees are enrolled under one family contract) the family deductible equals the sum of the individual deductibles divided by two.
***	If a covered person requests a brand-name drug when a generic substitute is available, he/she will be required to pay the non-formulary brand copayment plus the difference between the brand and generic price of the drug, or the price of the drug, whichever is less. If a brand-name drug does not have a generic substitute available and is not listed in the formulary, the non-formulary brand copayment will apply.

Mail Order Prescription Program – with Express Scripts Home Delivery, members order maintenance prescription medications and have them delivered directly to their home by first class mail or United Parcel Service. The Home Delivery Program provides a 90-day supply for twice the monthly copayment.

**** Well Child Services- Well Child Services is a benefit available for insured dependent children up to the age of 16 years. This benefit covers the following services for each visit: history, physical exam, developmental assessment, and anticipatory guidance, appropriate immunizations and lab tests. Benefits will be paid for charges made by the provider of these services for each visit, to a maximum of 18 visits as outlined. Visits must be made at these approximate age intervals: (a) birth; (b) 2 months; (c) 4 months; (d) 6 months; (e) 9 months; (f) 12 months; (g) 15 months; (h) 19 months; (i) 2 years; (j) 3 years; (k) 4 years; (l) 5 years; (m) 6 years; (n) 8 years; (o) 10 years; (p) 12 years; (q) 14 years; and @ 16 years.

***** Effective January 1, 2006.

***** No copay for allergy serum dispensed by physician in physician office. Deductible and/or copay only apply to injection of serum

PCP – Primary Care Physician is defined as family/general practice, internal medicine, and pediatric physicians.

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 calendar 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 HealthCare 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 50% 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 50% co-insurance.
- Once the calendar 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 HealthCare ID Card.

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.

SCHEDULE OF BENEFITS – Open Access Plus PREMIUM

NOTE: Deductibles must first be met unless otherwise indicated.

BENEFIT FEATURE	IN-NETWORK		OUT-OF-NETWORK	
CALENDAR YEAR DEDUCTIBLE: A covered person has two separate deductibles: In-Network and Out-of-Network. The deductible amounts are maximums. Deductible amounts met in October, November and December apply toward the current year and the following year.				
Income to \$10,000	INDIVIDUAL	FAMILY**	INDIVIDUAL	FAMILY**
\$10,001 - \$20,000	\$100	\$200	\$200	\$400
\$20,001 - \$40,000	\$225	\$450	\$350	\$700
Over \$40,000	\$250	\$500	\$400	\$800
	\$400	\$800	\$600	\$1,200
Maximum Out-of-Pocket Expense (Each calendar year, including copayments, not including deductible)	Calendar Year Out of Pocket Maximums: A covered person has two separate Out-of-Pocket Maximums: In-Network and Out-of Network.			
Income to \$10,000	\$2,025	\$4,050	\$4,050	\$8,100
\$10,001 - \$20,000	\$3,040	\$6,080	\$6,080	\$12,160
\$20,001 - \$40,000	\$4,050	\$8,100	\$8,100	\$16,200
Over \$40,000	\$5,063	\$10,125	\$10,125	\$20,250
Your Coinsurance	20% unless otherwise indicated		40% unless otherwise indicated	
Maximum Benefit - Lifetime			Unlimited	
COVERED SERVICES (after deductible is met, unless otherwise indicated)				
NOTE: All of the following services may be subject to review for medical necessity.				
HOSPITAL SERVICES	Semi-Private Room Limit			
Inpatient Expenses*	80% coverage		60% coverage	
Outpatient Expenses*	80% coverage		60% coverage	
EMERGENCY CARE SERVICES				
Illness or Accidental Injury (Within 90 days of Injury) Not Resulting in Hospital Admission	\$300 copay & 80% coverage		\$300 copay & 60% coverage	
Life-threatening Illness Resulting in Hospital Admission	80% coverage		60% coverage	
Urgent Care	80% coverage		60% coverage	
PROFESSIONAL SERVICES	PCP#	Specialist		
Office visits	\$20 copay	\$40 copay	60% coverage	

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
PROFESSIONAL SERVICES		
Well Child Services (Covered charges) ****	100% coverage, deductible waived (From birth to age 16) (according to Health Care Reform Act Preventive Care Guidelines Δ)	60% coverage, deductible waived (From birth to age 16)
Routine Preventive Care (including OB/Gyn Preventive Care, limited to one visit per year)	100% coverage, deductible waived (Age 17 and above) (according to Health Care Reform Act Preventive Care Guidelines Δ)	Not covered
Adult Immunizations (as recommended by CDC)*****	100% coverage, deductible waived (according to Health Care Reform Act Preventive Care Guidelines Δ)	Not covered
Allergy Injections*****	PCP# Specialist \$20 copay \$40 copay (or cost, whichever is less)	60% coverage
Maternity Services*	80% coverage	60% coverage
Surgery		
Inpatient	80% coverage	60% coverage
Outpatient	80% coverage	60% coverage
In-Hospital Visits	80% coverage	60% coverage
Diagnostic Services*		
Outpatient or Inpatient Setting	80% coverage	60% coverage
Independent Lab	80% coverage	60% coverage
Physician Office	PCP# Specialist \$20 copay \$40 copay	60% coverage
Advanced Radiological Imaging (ex: MRA, MRI, CT, PET) Any Setting	\$100 copay & 80% coverage	\$100 copay & 60% coverage
Ambulance	80% coverage	60% coverage
Anesthesiology	80% coverage	60% coverage
Second Opinion	\$40 Specialist copay	60% coverage
SPECIFIED THERAPIES*		
To include Physical, Occupational, Speech, Cardiac, Spinal Manipulation (Chiropractic Therapy). Limited to 50 days combined maximum per calendar year.	\$25 per office visit copay	60% coverage
MISCELLANEOUS SERVICES		
Home Health Care* (100 days maximum per calendar year)	80% coverage	60% coverage
Skilled Nursing Facility and Rehabilitation Facility* (120 days combined maximum per calendar year)	80% coverage	60% coverage
Durable Medical Equipment* External Prosthetic Appliance	80% coverage 80% coverage	60% coverage 60% coverage

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
HOSPICE SERVICES		
Inpatient Services	80% coverage	60% coverage
Outpatient Services	80% coverage	60% coverage
DENTAL SERVICES		
Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth, as well as hospitalization charges due to a medical condition necessitating a hospital setting		
Accidental Injury to Sound Teeth (Professional services and hospitalization)	80% coverage	60% coverage
Removal of Impacted Teeth When Hospitalization Required * (Hospital charges only)	80% coverage	60% coverage
Temporomandibular Joint Dysfunction (TMJ) *(Surgical charges only)	80% coverage	60% coverage
TRANSPLANTS * Includes all medically appropriate, non-experimental transplants		
Inpatient Facility	100% at a LifeSource Center deductible waived, otherwise 80%	60% coverage
Physician Services	100% at a LifeSource Center deductible waived, otherwise 80%	60% coverage

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS ***	<p>Participating Retail Pharmacy - <i>Up to a 30-day supply for non-maintenance medications at retail</i> \$7 copay generic \$30 copay brand name in formulary \$60 copay brand name not in formulary \$75 copay medications more than \$1,500</p> <p><i>Maintenance drugs must be filled using one of the following 2 options:</i></p> <p><u>Option 1 (Preferred):</u> Express Scripts Home Delivery– 2 copays for 90-day supply of maintenance medications \$14 copay generic \$60 copay brand name in formulary \$120 copay brand name not in formulary \$150 copay medications more than \$1,500 for a 30-day supply</p> <p><u>Option 2:</u> 90 Day Retail Program– 3 copays for 90-day supply of maintenance medications at selected retail pharmacies \$21 copay generic \$90 copay brand name in formulary \$180 copay brand name not in formulary \$225 copay medications more than \$1,500 for a 30-day supply</p> <p><i>Please note that on the fourth fill of a maintenance medication for a 30-day supply at retail, the copay is 100% of the Express Scripts discounted cost of the medication.</i></p>	<p>Coinsurance or copayment plus the difference in cost between out-of-network and network cost to the plan</p>

Δ <http://www.healthcare.gov/law/about/provisions/services/lists.html>

* Service may require precertification and/or prior authorization. Non-compliance can result in a PENALTY UP TO \$500. (See handbook for detailed explanation.)

** In situations of half-family (when married employees are enrolled under one family contract) the family deductible equals the sum of the individual deductibles divided by two.

*** If a covered person requests a brand-name drug when a generic substitute is available, he/she will be required to pay the non-formulary brand copayment plus the difference between the brand and generic price of the drug, or the price of the drug, whichever is less. If a brand-name drug does not have a generic substitute available and is not listed in the formulary, the non-formulary brand copayment will apply.

Mail Order Prescription Program – with Express Scripts Home Delivery, members order maintenance prescription medications and have them delivered directly to their home by first class mail or United Parcel Service. The Home Delivery Program provides a 90-day supply for twice the monthly copayment.

****	Well Child Services- Well Child Services is a benefit available for insured dependent children up to the age of 16 years. This benefit covers the following services for each visit: history, physical exam, developmental assessment, and anticipatory guidance, appropriate immunizations and lab tests. Benefits will be paid for charges made by the provider of these services for each visit, to a maximum of 18 visits as outlined. Visits must be made at these approximate age intervals: (a) birth; (b) 2 months; (c) 4 months; (d) 6 months; (e) 9 months; (f) 12 months; (g) 15 months; (h) 19 months; (i) 2 years; (j) 3 years; (k) 4 years; (l) 5 years; (m) 6 years; (n) 8 years; (o) 10 years; (p) 12 years; (q) 14 years; and (r) 16 years.
*****	Effective January 1, 2006.
*****	No copay for allergy serum dispensed by physician in physician office. Deductible and/or copay only apply to injection of serum
#	PCP – Primary Care Physician is defined as family/general practice, internal medicine, and pediatric physicians.

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 calendar 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 HealthCare 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 60% 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 40% co-insurance.
- Once the calendar 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 HealthCare ID Card.

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.

CIGNA Open Access Plus BASIC & PREMIUM 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 HealthCare.

If admission is due to an emergency, you or a member of your family, and your physician must call CIGNA HealthCare 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 HealthCare 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 HealthCare 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 HealthCare ID card, 1.800.CIGNA24 (1.800.244.6224).

The CIGNA HealthCare Chronic Condition Support Program

Your CIGNA HealthCare plan includes the CIGNA HealthCare Chronic Condition Support Program for better health. It offers valuable, confidential support for you and your covered family members with specific medical conditions. The CIGNA HealthCare Chronic Condition Support 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 HealthCare Chronic Condition Support 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 the toll-free number on your CIGNA HealthCare ID card, 1.800.CIGNA24 (1.800.244.6224) or 1.877.238.6863.

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 HealthCare Healthy Babies® (Well Pregnancy Program)

The CIGNA HealthCare 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 HealthCare 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, Lamaze classes are "free of charge" at specified locations.

Please call CIGNA HealthCare at the toll-free number on your CIGNA HealthCare ID card, 1.800.CIGNA24 (1.800.244.6224).

Weight Phases Program

This program is designed to assist the individual with a Body Mass Index (BMI) of 33 with one major risk factor or 35 or above without any risk factors. Components of the program include supervised exercise training three times per week; monthly fitness evaluations with an Exercise Specialist; weekly weigh-ins; nutritional tips, calorie recommendations, recipes and educational material. Weight Phases participants pay a monthly fee directly to the Orlando Regional Wellness Center. After successful completion of all the program requirements, participants are eligible to receive a percentage reimbursement. To qualify for this program, participants must:

- Be more than 14 years old
- Have a Body Mass Index (BMI) of 33 with one major risk factor or 35 or above without any risk factors
- Obtain a physician's approval if requested by Orlando Regional Wellness Center

Contact the Orlando Regional Wellness Center at 407.237.6351.

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 and reimbursement for any prescription or over-the-counter (OTC) nicotine replacement and group therapy costs. "Smoke-Free" participants pay for any prescription copayments, OTC costs and group therapy copayments. 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. 2929 to obtain an enrollment packet.

The CIGNA HealthCare 24-Hour Health Information Line

No matter where you are in the U.S., you can call the CIGNA HealthCare 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 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 HealthCare 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 HealthCare 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. Covered charges do not include charges for an injury or illness or any related conditions that existed prior to the date the person becomes insured. This limit will not apply to expenses for that injury, illness, or related condition that are incurred after the end of twelve (12) consecutive months in which the person was continuously insured. Pre-existing condition exclusions do not apply to pregnancy or to dependent children up to age nineteen (19).
2. 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.
3. 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.
4. 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.
5. Surgery to reverse surgical sterilization procedures.
6. Services and supplies related to sexual dysfunctions or inadequacies, or for sex change operations.
7. Fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or invitro fertilizations.
8. 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 6 months of the accident. The contributing cause of the accident must be something other than teeth grinding, chewing, or biting.
9. 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).
10. Non-surgical treatment involving bones and joints of the jaw and facial region. All orthognathic procedures and other craniomandibular disorder treatments not medically necessary.
11. 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.
12. Routine hearing examinations, routine physical examinations, premarital examinations, pre-employment physicals, preschool examinations, or annual boosters except as indicated in the Schedule of Benefits.

13. Hearing aids or examination for prescriptions or fitting of hearing aids.
14. 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.
15. 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.
16. Any organ or tissue transplant, except as otherwise listed in the Plan Document.
17. 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.
18. Education (excluding diabetes education), training, or counseling of any type no matter what the diagnosis. The mental health benefit covers counseling.
19. 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.
20. 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>.
21. 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.
22. Any personal items while hospital confined.

23. 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.
24. 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.
25. Medical supplies such as adhesive tape, antiseptics, or other common first aid supplies.
26. 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.
27. 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.
28. Those services which a covered person would not be legally obligated to pay if health insurance coverage did not exist.
29. 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.
30. Illness resulting from war, whether declared or undeclared.
31. 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.
32. Any charges in excess of approved charges as determined by CIGNA.
33. Claims not processed within 12 months from the date of service.
34. All charges during a hospitalization deemed medically unnecessary or inappropriate by the medical director or his designee.
35. Penalties for failure to comply with any and all applicable precertification requirements.
36. 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.
37. Charges for the first \$10,000 of bodily injury to a person while riding a motorcycle without a helmet.
38. Any tests not requiring a physician's order and purchased over-the-counter.
39. 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.
40. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

ADDITIONAL FORMS TO COMPLETE

1. OCPS Medical Enrollment Form.

II. MEDICAL INSURANCE

B. CIGNA OA Plus In-Network (Network BASIC) & Network PREMIUM

II. MEDICAL INSURANCE

B. CIGNA OA Plus In-Network (Network Basic) & Network PREMIUM

OVERVIEW

The CIGNA HealthCare Network plans are designed to provide high quality healthcare to you and your family. You must choose a “Primary Care Physician” (PCP) who specializes in one of four areas: family practice, internal medicine, general medicine or pediatrics. Referrals from your PCP are required to see a specialist.* 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 CIGNA HealthCare 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 OA Plus In-Network (Network BASIC) plan visit www.cigna.com. (choose: Provider Directory, then Open Access Plus ONLY). To access an online provider directory for the CIGNA Network PREMIUM plan visit www.cigna.com, choose "provider directory," choose "Network (HMO) Plans" then select “FL – Orlando” as your network area.

CIGNA HealthCare 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.

*Referrals required except in the following situations:

1. Chiropractors – no referral needed; members may self-refer
2. Podiatrists – no referral needed; members may self refer
3. OB/GYN – no referral needed; members may self-refer
4. Dermatologists – no referral needed for the first five visits per calendar year.

SCHEDULE OF BENEFITS

BENEFIT FEATURE	OA Plus In-Network (Network BASIC)	Network PREMIUM
Maximum Benefit - Lifetime	Unlimited	Unlimited
Maximum Out-of-Pocket Expense (each calendar year, including copayments, not including deductible).	Individual Family \$6,450 \$12,900	Individual Family \$3,040 \$6,080
Calendar Year Deductible; Deductible amounts met in October, November, and December apply toward the current year and the following year (applies to the BASIC plan only).	\$500 individual/\$1,000 family	None
	COVERED SERVICES (AFTER DEDUCTIBLE IS MET, UNLESS OTHERWISE INDICATED) NOTE: All of the following services may be subject to review for medical necessity.	COVERED SERVICES (NO DEDUCTIBLE) NOTE: All of the following services may be subject to review for medical necessity.
HOSPITAL SERVICES	Semi-Private Room Limit	Semi-Private Room Limit
Inpatient Expenses* (Including Maternity)	80% coverage	90% coverage
Outpatient Expenses*	80% coverage	90% coverage
Outpatient Surgery*	80% coverage	90% coverage
EMERGENCY CARE SERVICES		
Illness/Accident Not Resulting in Hospital Admission	\$300 copay	\$300 copay
Life-threatening Illness/Accident Resulting in Hospital Admission	80% coverage	90% coverage
Urgent Care	\$35 copay	\$35 copay

BENEFIT FEATURE	OA Plus In-Network (Network BASIC)	Network PREMIUM
PROFESSIONAL SERVICES		
Office Visits	\$20 for PCP** or \$35 for Specialist copay/visit	100% coverage after \$20 for PCP** or \$40 for Specialist copay/visit
Allergy Injections*****	\$20 for PCP** or \$35 for Specialist copay/visit (or cost, whichever is less)	100% coverage after \$20 for PCP** or \$40 for Specialist copay/visit (or cost, whichever is less)
Preventive Care: Routine Preventive Care: Well- Child Services**** (from birth thru age 16)	100% coverage, deductible waived (according to Health Care Reform Act Preventive Care Guidelines Δ)	100% coverage (according to Health Care Reform Act Preventive Care Guidelines Δ)
Adult and Well-Woman: OB/GYN wellness visits (age 17 and above, limited to one visit per year)	100% coverage, deductible waived (according to Health Care Reform Act Preventive Care Guidelines Δ)	100% coverage (according to Health Care Reform Act Preventive Care Guidelines Δ)
Adult Immunizations (as recommended by CDC)*****	100% coverage, deductible waived (according to Health Care Reform Act Preventive Care Guidelines Δ)	100% coverage (according to Health Care Reform Act Preventive Care Guidelines Δ)
Maternity Services* (Not including hospital expenses)	\$35 for initial visit	\$40 for initial visit
Maternity Services (Inpatient)	80% coverage	90% coverage
Surgery:		
Inpatient	80% coverage	90% coverage
Outpatient	80% coverage	90% coverage
In-Hospital Visits	80% coverage	90% coverage
Diagnostic Services*		
Outpatient Setting	80% coverage	90% coverage
Inpatient Setting	100% coverage	90% coverage
Independent Lab	100% coverage	100% coverage
Physician Office	100% coverage	100% coverage
Advanced Radiological Imaging (examples: MRA, MRI, CT, PET) (any setting)	\$100 per procedure copay	\$100 per procedure copay
Ambulance	80% coverage	90% coverage
Anesthesiology	80% coverage	90% coverage
Second Opinion	\$35 Specialist copay	\$40 Specialist copay
SPECIFIED THERAPIES		
To Include Physical, Occupational, Speech, Cardiac, Spinal manipulation (Chiropractic Therapy). Limited to 50 days combined maximum per calendar year.	\$25 per office visit copay	\$25 per office visit copay

BENEFIT FEATURE	OA Plus In-Network (Network BASIC)	Network PREMIUM
MISCELLANEOUS SERVICES		
Home Health Care* (Maximum 100 days per calendar year)	100% coverage	100% coverage
Skilled Nursing Facility and Rehabilitation Facility* (120 days combined maximum per calendar year)	80% coverage	90% coverage
Durable Medical Equipment*	100% coverage	100% coverage
HOSPICE SERVICES		
Inpatient Services	80% coverage	90% coverage
Outpatient Services	80% coverage	100% coverage
DENTAL SERVICES		
Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth, as well as hospitalization charges due to a medical condition necessitating a hospital setting		
Accidental Injury to Sound Teeth (Professional services and hospitalization)	80% coverage	90% coverage
Removal of Impacted Teeth When Hospitalization Required* (Hospital charges only)	80% coverage	90% coverage
TRANSPLANTS * Includes all medically appropriate, non-experimental transplants		
Inpatient Facility	100%, deductible waived, at Lifesource center, otherwise same as plan's Inpatient Hospital Facility benefit	100% coverage
Outpatient Services	100%, deductible waived, at Lifesource center; otherwise 80% after plan deductible	100% coverage
Travel maximum	\$10,000 per transplant (only available if using Lifesource facility)	\$10,000 per transplant (only available if using Lifesource facility)

BENEFIT FEATURE	OA Plus In-Network (Network BASIC)	Network PREMIUM
PRESCRIPTION DRUGS *** (At participating pharmacies)	<p>Participating Retail Pharmacy – <i>Up to a 30-day supply for non-maintenance medications at retail</i> \$7 copay generic</p> <p>◆20% coinsurance/minimum \$30 copay brand name in formulary</p> <p>◆50% coinsurance/minimum \$60 copay brand name not in formulary</p> <p>◆20% coinsurance/minimum \$75 copay medications more than \$1,500</p> <p><i>Maintenance drugs must be filled using one of the following two options:</i></p> <p><u>Option 1 (Preferred):</u> Express Scripts Home Delivery – 2 copays for 90-day supply of maintenance medications \$14 copay generic</p> <p>◆20% coinsurance/minimum \$60 copay brand name in formulary</p> <p>◆50% coinsurance/minimum \$120 copay brand name not in formulary</p> <p>◆20% coinsurance/minimum \$150 copay medications more than \$1,500</p> <p><u>Option 2:</u> 90 Day Retail Program – 3 copays for 90-day supply of maintenance medications at selected retail pharmacies \$21 copay generic</p> <p>◆20% coinsurance/minimum \$90 copay brand name in formulary</p> <p>◆50% coinsurance/minimum \$180 copay brand name not in formulary</p> <p>◆20% coinsurance/minimum \$225 copay medications more than \$1,500</p> <p><i>Please note that on the fourth fill of a maintenance medication for a 30-day supply at retail, the copay is 100% of the Express Scripts discounted cost of the medication.</i></p>	<p>Participating Retail Pharmacy - <i>Up to a 30-day supply for non-maintenance medications at retail</i> \$7 copay generic \$30 copay brand name in formulary \$60 copay brand name not in formulary \$75 copay medications more than \$1,500</p> <p><i>Maintenance drugs must be filled using one of the following 2 options:</i></p> <p><u>Option 1 (Preferred):</u> Express Scripts Home Delivery– 2 copays for 90-day supply of maintenance medications \$14 copay generic \$60 copay brand name in formulary \$120 copay brand name not in formulary \$150 copay medications more than \$1,500 for a 30-day supply</p> <p><u>Option 2:</u> 90 Day Retail Program– 3 copays for 90-day supply of maintenance medications at selected retail pharmacies \$21 copay generic \$90 copay brand name in formulary \$180 copay brand name not in formulary \$225 copay medications more than \$1,500 for a 30-day supply</p> <p><i>Please note that on the fourth fill of a maintenance medication for a 30-day supply at retail, the copay is 100% of the Express Scripts discounted cost of the medication</i></p>
<p>◆(1) Member pays coinsurance percentage or copayment, whichever is greater; (2) Percentage based on the discounted cost of the drug; (3) \$300 copayment maximum for a 30-day supply.</p>		

Δ <http://www.healthcare.gov/law/about/provisions/services/lists.html>

* Service may require precertification and/or prior authorization. (See handbook pages for detailed explanation.)

** Primary care physician copayments (\$20) apply to family/general practice, internal medicine and pediatric physicians who treat and coordinate your healthcare. Specialist physician copayments are \$35/\$40.

*** If a covered person requests a brand-name drug when a generic substitute is available, he/she will be required to pay the non-formulary brand copayment plus the difference between the brand and generic price of the drug, or the price of the drug, whichever is less. If a brand-name drug does not have a generic substitute available and is not listed in the formulary, then the non-formulary brand copayment will apply.

Mail Order Prescription Program – with Express Scripts Home Delivery, members order maintenance prescription medications and have them delivered directly to their home by first class mail or United Parcel Service. The Home Delivery Program provides a 90-day supply for twice the monthly copayment.

**** Well Child Services - Well Child Services is a benefit available for insured dependent children up to the age of 16 years. This benefit covers the following services for each visit: history, physical exam, developmental assessment, and anticipatory guidance, appropriate immunizations and lab tests. Benefits will be paid for charges made by the provider of these services for each visit, to a maximum of 18 visits as outlined. Visits must be made at these approximate age intervals: (a) birth; (b) 2 months; (c) 4 months; (d) 6 months; (e) 9 months; (f) 12 months; (g) 15 months; (h) 19 months; (i) 2 years; (j) 3 years; (k) 4 years; (l) 5 years; (m) 6 years; (n) 8 years; (o) 10 years; (p) 12 years; (q) 14 years; and (r) 16 years.

***** Effective January 1, 2006.

***** No copay for allergy serum dispensed by physician in physician office. Copay only applies to injection of serum.

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.

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.

Your Primary Care Physician is the key to obtaining the highest level of benefits under your health plan. The Primary Care Physicians have been carefully selected to provide and manage all of the medical care needs for you and your family. 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. Please contact your physician to ensure your elective hospitalization or procedure has been precertified five (5) days prior to services being rendered. Your care must be provided by participating providers in order to receive benefits unless a non-participating provider has been pre-authorized to provide services by CIGNA HealthCare.

If your Primary Care Physician feels you require the services of a specialist, he or she can coordinate your health care needs to a participating CIGNA HealthCare physician. Referrals are required; you pay the appropriate copayment amount for an office visit.

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 HealthCare

If admission is due to an emergency, you or a member of your family, and your physician must call CIGNA HealthCare 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 may be visited by a CIGNA HealthCare nurse to assist with any discharge needs you may have.

In non-life threatening situations that occur inside or outside the CIGNA HealthCare service area, please call your Primary Care Physician before you seek emergency care services. Your Primary Care Physician can then direct you for appropriate care. Chronic or less severe problems should be handled during routine office hours. Any unauthorized medical expenses incurred for non-emergency services may result in no benefits. Primary Care Physicians are required to provide coverage 24 hours a day, including weekends and holidays.

In life-threatening situations, such as severe chest pain, unconsciousness, uncontrolled bleeding, severe shortness of breath, convulsions or multiple injuries, go directly to the nearest emergency facility. If admission to the hospital is required, have the emergency department or a family member contact your Primary Care Physician and CIGNA HealthCare. **Always contact your Primary Care Physician within 24 hours of an emergency visit.**

If you are outside of the CIGNA HealthCare service area and require emergency care, go to the nearest medical facility for treatment. Please call your Primary Care Physician and CIGNA HealthCare within 24 hours of receiving such care. Non-emergency medical care incurred out of the service area, or lack of notification, will result in no benefits. Please refer to your schedule of benefits for coinsurance, copayment or other requirements of your benefit plan.

All follow-up care, such as suture removal, x-ray, lab work, or revisits, should be coordinated by your Primary Care Physician.

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 HealthCare 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 HealthCare ID card, 1.800.CIGNA24 (1.800.244.6224).

The CIGNA HealthCare Chronic Condition Support Program

Your CIGNA HealthCare plan includes the CIGNA HealthCare Chronic Condition Support Program for better health. It offers valuable, confidential support for you and your covered family members with specific medical conditions. The CIGNA HealthCare Chronic Condition Support 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 HealthCare Chronic Condition Support 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 the toll-free number on your CIGNA HealthCare ID card, 1.800.CIGNA24 (1.800.244.6224) or 1.877.238.6863.

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 HealthCare Healthy Babies® (Well Pregnancy Program)

The CIGNA HealthCare 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 HealthCare 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, Lamaze classes are “free of charge” at specified locations.

Please call CIGNA HealthCare at the toll-free number on your CIGNA HealthCare ID card, 1.800.CIGNA24 (1.800.244.6224).

Weight Phases Program

This program is designed to assist the individual with a Body Mass Index (BMI) of 33 with one major risk factor or 35 or above without any risk factors. Components of the program include supervised exercise training three times per week; monthly fitness evaluations with an Exercise Specialist; weekly weigh-ins; nutritional tips, calorie recommendations, recipes and educational material. Weight Phases participants pay a monthly fee directly to the Orlando Regional Wellness Center. After successful completion of all the program requirements, participants are eligible to receive a percentage reimbursement. To qualify for this program, participants must:

- Be more than 14 years old
- Have a Body Mass Index (BMI) of 33 with one major risk factor or 35 or above without any risk factors
- Obtain a physician's approval if requested by Orlando Regional Wellness Center

Contact the Orlando Regional Wellness Center at 407.237.6351.

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 and reimbursement for any prescription or over-the-counter (OTC) nicotine replacement and group therapy costs. “Smoke-Free” participants pay for any prescription copayments, OTC costs and group therapy copayments. 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. 2929, to obtain an enrollment packet.

The CIGNA HealthCare 24-Hour Health Information Line

No matter where you are in the U.S., you can call the CIGNA HealthCare 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 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 HealthCare 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 HealthCare 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. Covered charges do not include charges for an injury or illness or any related conditions that existed prior to the date the person becomes insured. This limit will not apply to expenses for that injury, illness, or related condition that are incurred after the end of twelve (12) consecutive months in which the person was continuously insured. Pre-existing condition exclusions do not apply to pregnancy or to dependent children up to age nineteen (19).
2. 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.
3. 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.
4. 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.
5. Surgery to reverse surgical sterilization procedures.
6. Services and supplies related to sexual dysfunctions or inadequacies, or for sex change operations.
7. Fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or invitro fertilizations.
8. 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 6 months of the accident. The contributing cause of the accident must be something other than teeth grinding, chewing, or biting.
9. 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).
10. Non-surgical treatment involving bones and joints of the jaw and facial region. All orthognathic procedures and other craniomandibular disorder treatments not medically necessary.
11. 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.
12. Routine hearing examinations, routine physical examinations, premarital examinations, pre-employment physicals, preschool examinations, or annual boosters except as indicated in the Schedule of Benefits.
13. Hearing aids or examination for prescriptions or fitting of hearing aids.

14. 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.
15. 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.
16. Any organ or tissue transplant, except as otherwise listed in the Plan Document.
17. 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.
18. Education (excluding diabetes education), training, or counseling of any type no matter what the diagnosis. The mental health benefit covers counseling.
19. 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.
20. 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>.
21. 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.
22. Any personal items while hospital confined.
23. 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.
24. 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.
25. Medical supplies such as adhesive tape, antiseptics, or other common first aid supplies.

26. 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.
27. 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.
28. Those services which a covered person would not be legally obligated to pay if health insurance coverage did not exist.
29. 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.
30. Illness resulting from war, whether declared or undeclared.
31. 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.
32. Any charges in excess of approved charges as determined by CIGNA.
33. Claims not processed within 12 months from the date of service.
34. All charges during a hospitalization deemed medically unnecessary or inappropriate by the medical director or his designee.
35. Penalties for failure to comply with any and all applicable precertification requirements.
36. 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.
37. Charges for the first \$10,000 of bodily injury to a person while riding a motorcycle without a helmet.
38. Any tests not requiring a physician's order and purchased over-the-counter.
39. 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.
40. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

ADDITIONAL FORMS TO COMPLETE

1. OCPS Medical Enrollment Form.

II. MEDICAL INSURANCE

C. EXPRESS SCRIPTS

(Your Pharmacy Benefits for ALL Medical Plans)

Express Scripts Pharmacy Benefits

Your Pharmacy Plan

Express Scripts, Inc. (ESI) 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 ESI home delivery 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 ESI discounted cost of the medication.**

ESI Home Delivery Pharmacy (Maintenance Drugs)

The Mail Order Prescription Program provides 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 Home Delivery- SAVE TIME AND MONEY

- Receive a 90-day supply
- Enjoy convenient delivery to your home (or specified address)
- Take advantage of toll-free customer service 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 an Express Scripts Home Delivery 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.express-scripts.com or by calling 1.877.493.1954.

Out-of-Area Services

If you are traveling outside the Central Florida area and need a prescription filled, call Express Scripts Customer Service at 1.877.493.1954.

Your Identification Card

You will find your copayment amounts in your OCPS Insurance Handbook. Remember to show your new Express Scripts ID card to your pharmacist each time you have a prescription filled.

Copayments

For each prescription you have filled, you will pay an out-of-pocket amount, called a copayment. For your copayment 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 the non-formulary brand copayment plus the difference between the brand and the generic price of the drug, or the retail price of the drug, whichever is less.

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 Express Scripts at 1.877.493.1954. The formulary is also available at www.express-scripts.com

Prior Authorization Program

Certain prescriptions require "clinical prior authorization" or approval before they will be covered. Please contact ESI clinical services at 1.800.417.8164 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 and Viral Hepatitis. Prescriptions for these drugs may be filled only Express Scripts' specialty pharmacy. Please call 1.866.848.9870 to enroll in this program.

EXPRESS SCRIPTS PARTICIPATING PHARMACIES

The following pharmacies are available at all locations in Orange, Seminole, Osceola, Brevard, Polk, Lake and Volusia Counties:

Albertsons, Costco, CVS, FamilyMeds Pharmacy, K-Mart, Publix, Sam's Club, Target, The Medicine Shoppe, Walmart and Winn –Dixie Stores. Please call Express Scripts at (877) 493-1954 if you are traveling; to locate the pharmacy closest to your home, or visit www.express-scripts.com and click on Locate a Pharmacy.

ORANGE COUNTY

APOPKA FAMILY HEALTH CENTER	225 E 7TH ST	APOPKA	FL	32703	(407) 886-6201
ATRIUM PHARMACY	10000 W COLONIAL DR	OCOE	FL	34761	(407) 296-1912
BIOSCRIP PHARMACY	942 N MILLS AVE	ORLANDO	FL	32803	(407) 897-5292
C & C COMMUNITY PHARMACY	2000 BRUTON BLVD	ORLANDO	FL	32805	(407) 295-6201
CHILDRENS HOME PHARMACY	4448 EDGEWATER DR	ORLANDO	FL	32804	(407) 513-3010
CHRIS CONAVAY	2304 ALOMA AVE	WINTER PARK	FL	32792	(407) 637-8300
CITY VIEW PHARMACY	595 W CHURCH ST	ORLANDO	FL	32805	(321) 206-9426
COLONIAL DRUGS	155 E NEW ENGLAND AVE	WINTER PARK	FL	32789	(407) 647-2311
CURASCRIP PHARMACY	6272 LEE VISTA BLVD STE 100	ORLANDO	FL	32822	(407) 852-4903
CYSTIC FIBROSIS PHARMACY	3901 E COLONIAL DR	ORLANDO	FL	32803	(407) 898-4427
DAVITA RX	2616 COMMERCE PK DR #500	ORLANDO	FL	32819	(407) 264-5100
DPHSCRIPTS	9400 TURKEY LAKE RD	ORLANDO	FL	32819	(321) 842-7230
FAMILY PHYSICIAN RX	2285 S SEMORAN BLVD	ORLANDO	FL	32822	(407) 381-3085
FL HOSPITAL COMMUNITY PHARMACY	2501 N ORANGE AVE, STE 235	ORLANDO	FL	32804	(407) 303-2559
FREEDOM PHARMACY	3901 E COLONIAL DR STE C	ORLANDO	FL	32803	(407) 898-4427
HARRISON'S PHARMACY	3333 CURRY FORD RD	ORLANDO	FL	32806	(407) 894-2373
HOMETOWN OLD COUNTRY PHARMACY	6918 ALOMA AVE	WINTER PARK	FL	32792	(407) 671-0003
INTEGRITY PHARMACY	6435 HAZELTINE NATIONAL DR	ORLANDO	FL	32822	(321) 281-3111
JR PHARMACY	2160 WHISPER LAKES BLVD	ORLANDO	FL	32837	(407) 447-5612
KNIGHT AIDE	4000 CENTRAL FLORIDA BLVD	ORLANDO	FL	32816	(407) 882-0600
LIFE SPECIALTY PHARMACY	1507 PARK CENTER DR	ORLANDO	FL	32835	(407) 522-5683
LIVING WELL FAMILY HEALTH CENTER	960 BACK STAGE LN	LAKE BUENA VISTA	FL	32830	(407) 934-2030
MAITLAND PRESCRIPTION SHOPPE	433 S ORLANDO AVE	MAITLAND	FL	32751	(407) 539-1110
MEDICINE SHOPPE	1724 S ORANGE AVE	ORLANDO	FL	32806	(407) 246-5588
MEDICINE SHOPPE PHARMACY	646 S DILLARD ST	WINTER GARDEN	FL	34787	(407) 656-0081
METROHEALTH	100 W GORE ST	ORLANDO	FL	32806	(407) 316-8898
METROHEALTH	100 W GORE ST	ORLANDO	FL	32806	(407) 316-8898
MINIER WATERFORD LAKES PHCY	12301 LAKE UNDERHILL RD	ORLANDO	FL	32828	(404) 249-8870
ORH SCRIPTS	1400 S ORANGE AVE MP-138	ORLANDO	FL	32806	(321) 841-2818
ORLANDO METHADONE TRTMT CNTR	601 S SEMORAN BLVD	ORLANDO	FL	32807	(407) 275-8939
ORLANDO ORTHOPEDIC CENTER	100 W GORE ST STE 500	ORLANDO	FL	32806	(904) 739-1309
ORLANDO PHARMACY	2909 N ORANGE AVE	ORLANDO	FL	32804	(407) 898-1331
PHD PHARMACY	6801-D W COLONIAL DR	ORLANDO	FL	32818	(407) 291-1236
PINE HILLS FAMILY HEALTH CNTR	1800 MERCY DR STE 200	ORLANDO	FL	32808	(407) 209-3303
PINE HILLS PHARMACY	1210 E COLONIAL DR STE 1	ORLANDO	FL	32803	(407) 896-3434
POSITIVE HEALTHCARE PHARMACY	1021 N MILLS AVE	ORLANDO	FL	32803	(407) 770-0507
PRINCETON PLAZA PHARMACY	1800 MERCY DR #100	ORLANDO	FL	32808	(407) 822-5015
RX MEDS PHARMACY	2751 N HIAWASSEE RD	ORLANDO	FL	32818	(407) 770-6077
SANDLAKE PHARMACY	7300 SANDLAKE COMMONS BLVD	ORLANDO	FL	32819	(407) 351-8002
SAVERITE	4520 S SEMORAN	ORLANDO	FL	32822	(407) 658-1349
SAVERITE	3201 W COLONIAL DR	ORLANDO	FL	32804	(407) 578-8151
SHARED PHARMACY SERVICES	2426 VISCOUNT ROW	ORLANDO	FL	32809	(407) 251-5492
SON CHAU	1287 N SEMORAN BLVD STE 200	ORLANDO	FL	32807	(407) 273-9410
TAYLORS PHARMACY	1021 W FAIRBANKS AVE	WINTER PARK	FL	32789	(407) 644-1025
TAYLOR'S PHARMACY	306 S PARK AVE	WINTER PARK	FL	32789	(407) 644-1025
THAI PHAM MD	713 W LANCASTER RD	ORLANDO	FL	32836	(407) 240-9905
TOWERS PHARMACEUTICAL SVCS	300 E CHURCH ST	ORLANDO	FL	32801	(407) 649-8050
UNIV OF CENTRAL FLORIDA PHCY	4000 CENTRAL FLORIDA BLVD	ORLANDO	FL	32816	(407) 823-6337
WEST GORE PHARMACY	100 W GORE ST STE 404	ORLANDO	FL	32806	(407) 481-7960
WESTMINSTER SENIOR CARE PHCY	76 W LUCERNE CR	ORLANDO	FL	32801	(407) 244-9280
WINTER GARDEN FAMILY HLTH CTR	1210 E PLANT ST	WINTER GARDEN	FL	34787	(407) 877-4301

OSCEOLA COUNTY					
COLONIAL DRUGS OF KISSIMMEE	728 N JOHN YOUNG PKWY	KISSIMMEE	FL	34741	(407) 344-5588
GENOA HEALTHCARE	208 PARK PLACE BLVD	KISSIMMEE	FL	34741	(407) 344-9700
MEDICINE SHOPPE PHARMACY	114 BROADWAY	KISSIMMEE	FL	34741	(407) 847-2424
MID FLORIDA TREATMENT CENTER	306 E OAK ST	KISSIMMEE	FL	34744	(407) 933-8331
PHARMACARE CENTER	400 CELEBRATION PLACE	CELEBRATION	FL	34747	(407) 303-4005
PRESCRIPTIONS UNLT HEALTHMART	2521 13TH ST STE A	SAINT CLOUD	FL	34769	(407) 892-7166
SAVERITE	1532 W VINE ST	KISSIMMEE	FL	34741	(407) 847-8337
SUPER SAVER PHARMACY	1901 S JOHN YOUNG PKWY	KISSIMMEE	FL	34741	(321) 284-4631
SUPER SAVER PHARMACY	2701 MICHIGAN AVE STE B	KISSIMMEE	FL	34744	(407) 343-1230
TURNER DRUGS	1530 CELEBRATION BLVD	CELEBRATION	FL	34747	(407) 566-9060
SEMINOLE COUNTY					
ADVANCED PHARMACY	45 SKYLINE DR STE 1011	LAKE MARY	FL	32746	(407) 805-8300
AMERICAN PHARMACEUTICAL SVSC	975 FLORIDA CENTRAL PKWY	LONGWOOD	FL	32750	(407) 261-5800
AXIUM HEALTHCARE PHARMACY	550 TECHNOLOGY PARK	LAKE MARY	FL	32746	(407) 865-7795
DISCOUNT RX	1700 W 1ST ST	SANFORD	FL	32771	(407) 322-2244
FERTILITY PHARMACY	5931 BRICK CT STE 150	WINTER PARK	FL	32792	(407) 557-2029
MED EX PHARMACY SERVICES	1455 E AIRPORT BLVD	SANFORD	FL	32773	(800) 310-7051
MEDICINE SHOPPE PHARMACY	3030 E SEMORAN BLVD	APOPKA	FL	32703	(407) 774-1957
MEDICINE SHOPPE PHARMACY	3796 HOWELL BRANCH RD	WINTER PARK	FL	32792	(407) 671-8070
NEW HOPE MEDICATIONS	1403 MEDICAL PLZ DR	SANFORD	FL	32771	(407) 302-3444
OVIDO DISCOUNT PHARMACY	85 GENEVA DR	OVIDO	FL	32765	(407) 366-2677
PHARMERICA	735 WEST HIGHWAY 434 STE B	LONGWOOD	FL	32750	(407) 767-9010
PILLS PLUS	181 SABAL PALM DR STE 102	LONGWOOD	FL	32779	(407) 682-3211
TRU VALU DRUGS	503 1ST ST E	SANFORD	FL	32771	(407) 323-6414
LAKE COUNTY					
BAY PHARMACY	2 E MAGNOLIA AVE	EUSTIS	FL	32726	(352) 357-4341
BELLEVUE COMMUNITY PHARMACY	2500 CITRUS BLVD	LEESBURG	FL	34748	(352) 728-0477
BURRY'S PHARMACY	500 WEBSTER ST	LEESBURG	FL	34748	(352) 787-3787
CORKREANS THE PHARMACIST	33124 COUNTY RD 473	LEESBURG	FL	34788	(352) 742-8080
GROVELAND PHARMACY	111 N LAKE AVE	GROVELAND	FL	34736	(352) 429-1353
LAKE PHARMACY	710 N BAY ST	EUSTIS	FL	32726	(352) 357-5485
MEDICAP PHARMACY	12302 ROPER BLVD	CLERMONT	FL	34711	(352) 243-6340
PAIN MANAGEMENT INSTITUTE	1216 MOUNT HOMER RD	EUSTIS	FL	32726	(352) 357-0688
SOUTH LAKE FAMILY HEALTH CNTR	1296 W BROAD ST	GROVELAND	FL	34736	(352) 429-4104
THE MEDICINE CHEST	211 S HWY 441-27	LADY LAKE	FL	32159	(352) 753-1877
UMATILLA DRUG STORE	901 N CENTRAL AVE	UMATILLA	FL	32784	(352) 669-1166
VINTAGE PHARMACY	906 AVENIDA CENTRAL	THE VILLAGE	FL	32159	(352) 751-6895
BREVARD COUNTY					
AMEX PHARMACY	1515 ELIZABETH ST STE J	MELBOURNE	FL	32901	(321) 872-0723
BROWNINGS PHARMACY & HLTH CARE	141 E HIBISCUS BLVD	MELBOURNE	FL	32901	(321) 725-6320
CIRCLES OF CARE	2020 COMMERCE DR	MELBOURNE	FL	32904	(321) 952-6020
CIRCLES OF CARE	1770 CEDAR ST	ROCKLEDGE	FL	32955	(321) 639-5706
EAST COAST PHARMACY	504 GARDEN ST	TITUSVILLE	FL	32796	(321) 593-4318
FAMILY DRUG MART	7135 N US HWY 1	PORT SAINT JOHN	FL	32927	(321) 631-0300
FIVE POINTS PHARMACY	1108 LAKE DR	COCOA	FL	32922	(321) 636-8433
HEALTH FIRST FAMILY PHARMACY	1350 S HICKORY ST	MELBOURNE	FL	32901	(321) 434-7355
HEMATOLOGY ONCOLOGY ASSOC	107 LONGWOOD AVE	ROCKLEDGE	FL	32955	(321) 626-2111
HOBB'S PHARMACY	119 N BANANA RIVER DR	MERRITT ISLAND	FL	32952	(321) 452-0010
MEDICINE SHOPPE PHARMACY	1555 PORT MALABAR BLVD NE	PALM BAY	FL	32905	(321) 725-7188
MEDICINE SHOPPE PHARMACY	1260 SARNO RD	MELBOURNE	FL	32935	(321) 242-2440
OMNI HEALTHCARE	1344 S APOLLO BLVD	MELBOURNE	FL	32901	(321) 727-2990
OMNI HEALTHCARE	6100 MINTON RD STE 103C	PALM BAY	FL	32907	(321) 308-0303
PALM BAY PHARMACY	1270 MALABAR RD SE STE 2	PALM BAY	FL	32907	(321) 952-0656
SAVERS DRUG MART	200 OCEAN AVE	MELBOURNE BEACH	FL	32951	(321) 725-5492
SPACE COAST PAIN INSTITUTE	595 N COURTNEY PKWY	MERRITT ISLAND	FL	32953	(321) 784-8211
SUNTREE PHARMACY	7025 N WICKHAM RD STE 113	MELBOURNE	FL	32940	(321) 253-3535

POLK COUNTY					
APOTHECARY SHOP	437 S 11TH ST	LAKE WALES	FL	33853	(863) 676-1174
AUBURNDALE COMMUNITY PHARMACY	200 HAVERDALE BLVD	AUBURNDALE	FL	33823	(863) 967-8009
CAREPLUS PHARMACY	3020 S COMBEE RD STE A	LAKELAND	FL	33803	(863) 668-8490
CLARK & DAUGHTREY MEDICAL GRP	1730 LAKELAND HILLS BLVD	LAKELAND	FL	33805	(863) 284-5040
CLEVELAND HEIGHTS PHARMACY	3405 CLEVELAND HEIGHTS BLVD	LAKELAND	FL	33803	(863) 646-5041
CLINIC PRESCRIPTION SHOP	1600 LAKELAND HILLS BLVD	LAKELAND	FL	33805	(863) 680-7235
FORT MEADE COMMUNITY PHARMACY	107 W BROADWAY ST STE B	FORT MEADE	FL	33841	(863) 285-9285
GENOA HEALTHCARE	1835 GILMORE AVE	LAKELAND	FL	33831	(863) 683-0449
GENOA HEALTHCARE	1201 1ST ST S	WINTER HAVEN	FL	33881	(863) 291-4707
HAVEN COMMUNITY PHARMACY	1460 6TH ST SE	WINTERHAVEN	FL	33880	(863) 294-1400
KT PHARMACY	490 E SUMMERLIN ST	BARTOW	FL	33830	(863) 533-4102
LAKELAND COMMUNITY PHARMACY	3133 S FLORIDA AVE	LAKELAND	FL	33803	(863) 464-2444
LAKELAND PHARMACY	2614 LAKELAND HILLS	LAKELAND	FL	33805	(863) 687-9700
LIDDY'S PHARMACY	4204 S FLORIDA AVE	LAKELAND	FL	33813	(863) 647-9899
MARTIN DRUG	437 S CENTRAL AVE	LAKELAND	FL	33815	(863) 683-2807
MEDICINE SHOPPE PHARMACY	1231 LAKELAND HILLS BLVD	LAKELAND	FL	33805	(863) 688-5427
MET DRUGS	4969 US HWY 98 N	LAKELAND	FL	33809	(863) 858-4444
MULBERRY LTC PHARMACY	1011 N CHURCH AVE	MULBERRY	FL	33860	(863) 425-1101
MULBERRY PHARMACY	1009 N CHURCH AVE	MULBERRY	FL	33860	(863) 425-1101
PHARMACY ONE PRO	65 3RD ST NW STE 59	WINTER HAVEN	FL	33881	(863) 401-9300
SENIOR CARE PHARMACY	5309 GREAT OAK DR	LAKELAND	FL	33815	(863) 577-1440
SWEETBAY SUPERMARKET	6220 US HWY 98 N	LAKELAND	FL	33809	(863) 858-4088
TRI-COUNTY PHARMACY	1807 CRYSTAL LAKE DR	LAKELAND	FL	33801	(863) 937-0480
WATSONS PHARMACY	16 W WALL ST	FROSTPROOF	FL	33843	(863) 635-3841

VOLUSIA COUNTY					
ACCARDI CLINICAL PHARMACY	2583 S VOLUSIA AVE	ORANGE CITY	FL	32763	(386) 774-5800
ACT BEHAVIORAL HLTHCARE PHCY	1220 WILLIS AVE BLDG 2	DAYTONA BEACH	FL	32114	(386) 236-1658
CAREPOINT PHARMACY	1400 HAND AVE STE O	ORMOND BEACH	FL	32174	(386) 671-9476
DAYTONA DISCOUNT PHARMACY	815 D BEVILLE RD	SOUTH DAYTONA	FL	32119	(386) 322-5969
DAYTONA METHADONE TRTMNT CNTR	737 W INTRNTL SPEEDWAY BLVD	DAYTONA BEACH	FL	32114	(386) 254-1931
DAYTONA PEOPLES PHARMACY	968 ORANGE AVE	DAYTONA BEACH	FL	32114	(386) 258-8171
DELTONA PHARMACY	776 DELTONA BLVD	DELTONA	FL	32725	(386) 574-7600
GUARDIAN PHARMACY	9 W TOWER CIR	ORMOND BEACH	FL	32174	(386) 615-1925
HOLLY HILL PHARMACY	1702 RIDGEWOOD AVE #C	HOLLY HILL	FL	32117	(386) 677-7377
LITTLE DRUG	412 CANAL ST	NEW SMYRNA BEACH	FL	32168	(386) 428-9041
MEDICINE SHOPPE PHARMACY	653 N DIXIE FWY	NEW SMYRNA BEACH	FL	32168	(386) 427-3459
MEDICINE SHOPPE PHARMACY	1232 8TH ST	DAYTONA BEACH	FL	32117	(386) 238-3777
MEDICINE SHOPPE PHARMACY	4036 DS NOVA RD	PORT ORANGE	FL	32127	(386) 304-8222
MEDICINE SHOPPE PHARMACY	319 S WOODLAND BLVD	DELAND	FL	32720	(386) 734-3383
PETER'S PHARMACY	1431 ORANGE CAMP RD STE 102	DELAND	FL	32724	(386) 734-8477
PIERSON COMMUNITY PHARMACY	112 E 1ST AVE	PIERSON	FL	32180	(386) 749-9557
RITTER'S TOWNE PHARMACY	120 E NEW YORK AVE	DELAND	FL	32724	(386) 734-6666
SAXON MEDICAL PHARMACY	1209 SAXON BLVD STE 6	ORANGE CITY	FL	32763	(386) 774-7933
STEVES PHARMACY	636 MASON AVENUE	DAYTONA BEACH	FL	32117	(386) 255-0907
THE MEDICINE SHOPPE	864 ORANGE AVE	DAYTONA BEACH	FL	32114	(386) 253-1691

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 BASIC plan members ages 45 to 79 for men and ages 55 to 79 for women.
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 drugs bearing a label: "Caution – limited by federal law to investigational use," or experimental drugs.
7. The refilling of a prescription in the amount greater than that authorized by the prescriber.
8. The refilling of a prescription at a point in time after one year from the date of issuance.
9. The filling or refilling of prescriptions not in compliance with applicable state and federal laws, rules and regulations.
10. Quantities in excess of a 90-day supply (100 pills may be dispensed if packaged in lots of 100).
11. Prescription drugs which may be properly received without charge under local, state, or federal programs including workers' compensation.
12. Prescription drugs for medical plan coverage exclusions such as sexual dysfunction or inadequacies, or infertility.
13. Diet medications or medications prescribed for weight control.
14. Contraceptives, Emergency and Abortive (e.g., Mifeprex, PlanB, Preven).
15. Impotency medications (e.g., Muse, Edex, Caverject, Viagra, Levitra, Cialis).
16. Fertility drugs, oral and injectable.
17. Oral Fluoride Preps, except for children older than 6 months of age through 5 years old.
18. Non-prenatal vitamins, with the exception of folic acid for women of child-bearing age (e.g. 18 to 45) and iron supplements for children ages 6 to 12 months who are at risk for iron deficiency anemia.
19. Nutritional/Dietary Supplements.
20. Medical foods.
21. Homeopathic drugs, all dosage forms including injectables.

22. Diagnostic, testing & imaging supplies (e.g. Tubersol for TB skin test, Radiopaque dye).
23. Prescriptions for Smoking Cessation medications are covered with a \$500 individual lifetime maximum.
24. Certain medications may be a part of the Express Scripts Drug Quantity Management Program. This program is designed to limit medications for both quantity and days supply based on safe prescribing guidelines from the FDA. Prior Authorizations may be allowed for some of these medications where applicable.
25. Prior Authorizations are required for the following medications before it can be dispensed: Acne-Topical (tretinoin) after the age of 24, Actiq, ADHD/Narcolepsy, Anabolic Steroids, Byetta, Fentora, Lamisil, Nuvigil, Parkinson's Disease (Apokyn), Penlac, Provigil, Regranex, Samsca, Sporanox, Symlin, Tazorac, Topemax, Victoza, and Zonegran.
26. Certain medications under Specialty Pharmacy will require prior authorization prior to filling the medication. Those medications include but are not limited to the following: Actemra, Adcirca, Amevive, Aralast, Arcalyst, Avonex, Berinert, Betaseron, Boniva IV, Botox (injectable), Cerezyme, Chenodal, Cimzia, Cinryze, Copaxone, Dysport, Enbrel, Erythropoietins, Extavia, Fabrazyme, Flolan, Forteo, Gileyna, Gleevec, Growth Hormones, Humira, Hyaluronic acid derivatives (for osteoarthritis), Ilaris, Immune Globulins, Increlex, Kalbitor, Kineret, Kuvan, Letairis, Leuprolide injections, Myobloc, Neulasta, Neupogen, Nplate, Onsolis, Orencia, Pegasys, PEG-Intron, Prolastin, Promacta, Raptiva, Rebif, Reclast, Remicade, Remodulin, Revatio, Rituxan, Simponi, Somavert, Stelara, Suboxone, Synagis, Tracleer, Tysabri, Tyvaso, Ventavis, Xenazine, Xeomin, Xolair, and Zemaira.
27. Certain categories will require Step Therapy. These medications will require that a first line agent is utilized prior to a second line brand agent. Step Therapy Programs include but are not limited to the following: ACE Inhibitors (blood pressure), ARB (blood pressure), Benign Prostatic Hyperplasia (urinary retention), Beta Blockers (blood pressure), Biphosphonates Enhanced (Bone Conditions), Blood Glucose Monitoring Supplies (diabetes), Calcium Channel Blockers (blood pressure), COX-II Inhibitors (Arthritis/pain), Dipeptidyl Peptidase-4 (DPP-4) Inhibitors (Diabetes), Erythropoietins, Fenofibrates (Blood Lipids), Growth Hormones, HMG Enhanced (Statin medications used for cholesterol), Hypnotics (sleep disorders), Inflammatory Conditions, Leukotrienes (allergies), Long-Acting Beta Agonists – LABA (asthma), Lyrica (neuropathic pain), Multiple Sclerosis, Nasal Steroids (allergies), NSAIDS (Arthritis/pain), Non-Sedating Antihistamines (allergies), Other Antidepressants including SNRI's (depression), Overactive Bladder (urinary conditions), Proton Pump Inhibitors (gastrointestinal conditions), SSRI (depression), Tektura (blood pressure), Tetracyclines (oral), Topical Corticosteroids and Immunomodulators (skin conditions), and TZD (oral diabetic medications).
28. Introduction of new medications-- Effective Jan. 1, 2010, new medications coming to the market will be in a "pending" status (that is, not covered under the OCPS plan) until reviewed and approved by the Express Scripts Pharmacy and Therapeutics (P & T) Committee for safety and effectiveness. A P & T 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, Express Scripts 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. Express Scripts 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 "pending" category will not be covered or reimbursed until approved. Since the P & T 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 Express Scripts Customer Service to check on the status of the drug in question.

II. MEDICAL INSURANCE

D. 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 at 407.317.3535, or through Orlando Behavioral Healthcare directly 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 (190-319) or DSM-IV when pre-authorized by Orlando Behavioral Healthcare.

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 Master's Level 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 1st through September 30th.

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.)	<u>Maximum***</u>		<u>Maximum***</u>
Inpatient Psychiatric	90% coverage	30 days/yr	Not covered
Long Term Intensive Care (LIC)*	90% coverage	60 -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**
ALCOHOLISM AND CHEMICAL DEPENDENCY (C.D.)	<u>Maximum***</u>		<u>Maximum***</u>
Inpatient Psychiatric	90% coverage	30 days/yr	Not covered
Long Term Intensive Care (LIC)*	90% coverage	60 -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**

*CD and MH LIC number of benefit days varies with level of intensity of treatment.

**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. Outpatient mental health services exceeding a maximum of 20 visits per plan year.
4. Outpatient services for the treatment of alcoholism, and drug addiction exceeding 44 outpatient visits per plan year.
5. Experimental procedure or procedures which have not been accepted as established standard medical practice.
6. 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.
7. 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.
8. Emergency outpatient psychiatric and substance abuse services not certified or provided by Orlando Behavioral Healthcare.
9. Medical evaluation resulting in a psychiatric diagnosis. The medical evaluation may be covered under other medical plan benefits.
10. 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.
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. 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.
13. 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.
14. 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.
15. Treatment for autism that is not pre-authorized by Orlando Behavioral Healthcare.
16. Treatment for autism exceeding \$36,000 per plan year.
17. Treatment for Mental Retardation except for the acute secondary psychiatric symptoms.
18. Treatment for obesity or weight loss.
19. 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.

II. MEDICAL INSURANCE

- E. ALTERNATIVES TO MEDICAL INSURANCE**
- F. ACCEPTANCE/WAIVER OF MEDICAL INSURANCE FOR
PART-TIME EMPLOYEES**

II. MEDICAL INSURANCE

E. ALTERNATIVES TO MEDICAL INSURANCE

The following options are available to employees having other group medical coverage (ex. their spouse's medical plan). These alternatives are available to eligible employees by contacting the OCPS Insurance Benefits Section at 407.317.3245. Eligible employees may select **ONE** of these alternatives. The alternative selected replaces the medical care benefits previously described. The precertification program does not apply to these alternatives.

This is an OCPS-paid benefit (no employee cost to full-time or part-time employees).

1. HOSPITAL INDEMNITY PLAN (HIP) Available for employees, not for dependents.

Daily Hospitalization Benefit.....Maximum \$225

Prescription Drug Benefit	\$7 copay generic
	\$30 copay brand name in formulary
	\$60 copay brand name not in formulary
	\$75 copay medications more than \$1,500

Up to a 30-day supply at retail. At in-network pharmacies only - no benefit for out-of-network pharmacies)

Please refer to Section II. D Express Scripts for more information on your Home Delivery prescription drug benefit.

Term Life Insurance.....\$10,000 with AD&D
(under age 70; percentage reduction thereafter)

NOTE: HIP benefit is payable to the covered person only. It is not assignable to providers.

OR

2. *DISABILITY/VISION PLAN*

Disability Benefit Available for employees, not for dependents

Monthly BenefitMaximum \$1,200
(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.

ADDITIONAL FORMS TO COMPLETE

1. Hospital Indemnity Plan - Complete the OCPS Medical Enrollment Form
2. Disability/Vision - Complete the Lincoln Enrollment Form (if enrolling after annual enrollment period)

II. MEDICAL INSURANCE

F. 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 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 employees' responsibility to contact Insurance Benefits if their status changes from part-time to full-time.

ADDITIONAL FORMS TO COMPLETE

None.

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. 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. 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 of:	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	50%
Maximum any one accident	100%

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 150 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.

ADDITIONAL FORMS TO COMPLETE

None.

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	\$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	\$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	\$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	\$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 means a person who meets the definition of a dependent of the Insured Person under the provision of the U.S. Internal revenue Code; and is an Insured Person's:

1. spouse who is not legally separated from the Insured Person;
2. unmarried child at least 14 days but less than 19 years of age;
3. 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
4. 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 or foster 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 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 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 also becomes insured for portable coverage.

The spouse 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 is the highest amount of life insurance available for spouses 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 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.

ADDITIONAL FORMS TO COMPLETE

None.

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

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)

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.

Eligibility

For 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.

During this year's annual enrollment, if you're **currently enrolled** in the GUL plan, you can increase your coverage in increments of \$10,000 to one times your annual salary rounded to the next higher \$10,000, to a *new total* maximum of two times your 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.

SPOUSE \$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 must not be legally separated from the employee and is not eligible for insurance as an employee. For the coverage to become effective, the employee must be actively at work and the spouse must not be hospitalized or confined because of illness or disease. The maximum amount of insurance available without a medical statement for spouses of NEWLY HIRED/NEWLY ELIGIBLE employees and spouses who enroll within 31 days after date of marriage is \$10,000. **Any spouse currently insured and wanting to increase coverage or any spouse 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 5 times the term amount due to loss of dependent eligibility. To be considered a dependent child, the child must be the unmarried natural, adopted, or stepchild or foster child of an employee who is

15 days of age, but less than 19 years old; 19 or more years old, but less than 25 years, enrolled in a school as a full-time or part-time student and primarily supported by the employee; 19 or more years old, and primarily supported by the employee, and incapable of self-sustaining employment by reason of mental or physical handicap. 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

No one can be covered as an employee and a dependent or spouse at the same time, or as the dependent of two employees.

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, 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. To apply for this benefit, contact Minnesota Life at 1.888.658.0193.

The Group Universal Life (GUL) program offers the following advantages to you

Portability

Participating employees, spouses 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 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 Minnesota Life at 1.866.293.6047.

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 Minnesota Life, 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 Minnesota Life Customer Service Center: 1.800.843.8358 Monday through Friday, 7:00 a.m. to 6:00 p.m. Central Time.

Designing Your Plan

For You and Your Spouse

Designing a Group Universal Life Plan for you and your spouse involves two simple steps. First, select the amount of life insurance coverage you and your spouse would like to have. Second, decide if you and/or your spouse 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, they may convert from term coverage to their own Group Universal Life Insurance plans, without providing medical evidence of good health. 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
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 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 \$_____	x	\$_____
		units		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 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 your or your spouse's monthly contribution if you select dependent child(ren) coverage.	+ \$_____	+	\$_____
	TOTAL MONTHLY CONTRIBUTION	= \$_____	=	\$_____

**Monthly Cost of Insurance
(Revised March 2010)**

Use these rates to determine the monthly cost of life insurance. To determine the cost of coverage, find your age or your spouse'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 Deductions are taken over 10 months (September through June) each plan year for 12 months of coverage	
*Age of Employee or Spouse	Monthly Cost of Insurance (Rates per \$10,000)
Less than 25	\$0.56
25-29	0.68
30-34	0.90
35-39	1.02
40-44	1.14
45-49	1.74
50-54	2.58
55-59	4.82
60-64	7.42
65-69	14.26
70-74	23.12

*Your age for calculating monthly premium will be updated on each plan anniversary date, October 1.

Effective October 1, 2010, the above costs will apply. 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 Minnesota 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 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 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 Minnesota Life at 1.866.293.6047

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 63 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 2011 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 2011 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 23 or more consecutive hours.

DURATION OF BENEFITS

The duration of benefits is based on your age when the disability occurs:

<u>Age at Disability</u>	<u>Maximum Benefit Period</u>
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.

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 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 and dependent children do not have to be traveling with you to be eligible. However, spouses traveling on business for their employer are not covered by this program.

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 PROGRAM³

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.

^{1,2} 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.

³ 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

Choosing Your Dental Plan

Check out the comparison chart below to learn more about the differences between Delta Dental PPO and DeltaCare USA plans.

Features	DeltaCare USA	PPO
Specialty Care	Easy referrals to specialty care dentists (referral from selected assigned dentist and preauthorization required).	No referral required for specialty care.
Covered Benefits	Wide range of covered services (including orthodontia in the DeltaCare USA Comprehensive plan).	Wide range of covered services.
Out-of-Area Coverage	Plan covers out-of-area emergency care (35 or more miles from assigned DeltaCare USA dentist); allowance up to \$100 per incident.	Visit any licensed dentist. With a large number of Delta dentists nationwide it's easy to find an in-network Delta dentist. This plan also has out-of-network benefits.
Deductibles and Maximums	No annual deductibles and no annual dollar maximums.	Annual deductibles and maximums apply.
Administration	No claim forms.	Claim forms filed by in-network Delta dentists.
Coinsurance/Copayment	All covered procedures have predetermined copayments.	Covered services paid at percentage of contract allowance.
Selecting a dentist	You must visit your selected/assigned dentist to receive benefits. Ability to change dentist monthly via telephone or Internet by contacting Delta Dental.	Freedom to visit any licensed dentist – no need to select a primary care dentist. When selecting an in-network dentist, your out-of-pocket expenses are likely less. Change dentists any time without contacting Delta Dental.
Participating dentists	Visit your selected/assigned DeltaCare dentist to receive benefits. Pay only the copayment at the time of treatment. NOTE: Enrollees on Basic plan have a 25% discount off the filed fees when a DeltaCare USA specialist is used.	You usually have the lowest out-of-pocket expenses when visiting a Delta Dental PPO dentist. If you don't see a PPO dentist, a Delta Dental Premier dentist is usually your next best option.

Compare Plan Features

Plan Features	DeltaCare USA	Delta Dental PPO
Copayments	Covered procedures have predetermined dollar copayments for services provided by network dentists (this means out-of-pocket costs are predictable)	Covered services paid at applicable percentage – for example, fillings are covered at 80% of allowed amount – you pay the remaining 20%
Coverage	Plan covers 250+ procedures No copayments or low copayments for most diagnostic and preventive services No exclusions for pre-existing conditions or missing teeth	Wide range of covered services No exclusions for pre-existing conditions
Dentist network	You must select a dentist from a list of network dental facilities and you must visit this dentist to receive benefits Easy referrals to a large specialty care network	Freedom to choose any licensed dentist No referral required for specialty care
Changing your dentist	Ability to change selected or assigned network dentists via telephone or Internet	Change dentists any time without contacting Delta Dental
Transitions from previous plan	Coverage is provided only for treatment started and completed after your effective date of coverage under the plan.	Coverage is provided for treatment started and completed after your effective date of coverage under the Delta Dental plan. Any dental treatment in progress when your coverage begins — such as root canals, crowns and bridgework — is not covered.
Orthodontic treatment in progress	Covers new enrollees who, on the effective date of their coverage, are in active treatment started under their previous employer-sponsored dental plan. Enrollees are responsible for all copayments and fees subject to the provisions of their prior dental plan.	Plan will pay the remaining amount of the total case fee not paid by your former dental plan. (Where plan includes orthodontic coverage)
Out-of-area coverage	Limited to emergency care allowance	Visit any licensed dentist
Deductibles and maximums	No annual deductible or annual dollar maximums	Deductibles and annual maximums apply to most plan designs
Claims	No claim forms required. You only need to pay the specified copayment at the time of your visit.	Delta Dental dentists file claim forms and accept payment directly from Delta Dental. Non-Delta Dental dentists may require payment up front, and require you to file a claim for reimbursement.

**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 \$75 per family per calendar year	\$50 per person \$150 per family per calendar year
PLAN YEAR MAXIMUM	N/A	N/A	\$1,250 per person per calendar year	\$1,250 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.

Eligibility for Enrollment

All of the Contractholder's retired employees and all permanent, present employees and regular part-time employees working 17.5 hours weekly who have completed 63 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 63 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;
- Children from birth to the end of the calendar year in which occurs their 25th 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, 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 25 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 25 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 25. 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

Welcome to DeltaCare USA

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.

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

Cost savings

- 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 except for accidental injury

Basic Managed Care Plan - FLM12

The DeltaCare USA Program covers the following types of care:

- | | |
|--|---|
| ✓ Preventive
(exams, X-rays, cleaning, fluoride treatments) | ✓ Major
(onlays, crowns, dentures, bridges) |
| ✓ Basic
(extractions, root canals, oral surgery, restorations) | ✓ Orthodontia
(covered in part for children and adults) |

The Program has certain limitations and exclusions (see Limitations and Exclusions of Benefits).

When you enroll, you select a contract dentist to provide services. The DeltaCare network consists of private practice dental facilities that have been carefully screened for quality.

- | | |
|---|--|
| ✓ Comprehensive benefits for you and your family. | ✓ No deductibles or annual dollar maximum on basic benefits.
<i>In our plan there are no deductibles to pay on basic benefits, so your benefits begin immediately.</i> |
| ✓ No restrictions on pre-existing conditions, except for work in progress. | ✓ Out-of-pocket costs are clearly defined. |
| ✓ Large, stable network of dentists, so you can enjoy a long-term relationship with your dentist. | ✓ Out-of-area dental emergency coverage up to \$100 per emergency. |
| ✓ Delta Dental maintains quality standards by visiting each contract dental facility every three months. | ✓ No annual dollar maximum except for accidental injury.
<i>The DeltaCare program provides coverage for accidental injury (caused by external forces) at 100% of the filed fees for benefits (less any applicable copayments). The enrollee must be eligible under the DeltaCare program when the accident occurs. Accidental injury benefits are subject to a \$1600 maximum, per 12 months, per person.</i> |
| ✓ No claim forms to complete.
<i>A predetermined copayment schedule eliminates the need for claim forms.</i> | |
| ✓ Specialists services. | |
| ✓ Expanded business hours for toll-free customer service, from 8 a.m. to 9 p.m., Eastern Time. | |

Easy Enrollment

School Board of Orange County employees have the choice of either the Basic Managed Care Plan FLM12 or the Comprehensive Managed Care Plan FLM11. Please be sure to read all the information contained in the booklets.

Next, review the list of managed care dental facilities. You and your eligible dependents may receive care from the same contract dentist, or you may select up to a maximum of three contract dentists to meet your family's needs.

Once you have made all of your choices, simply complete the enrollment process as directed by your benefits administrator.

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 web site (www.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 have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

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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-2009 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
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral <i>radiographs</i> - complete series (including bitewings) - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0270	Bitewing <i>radiograph</i> - single film	No Cost
D0272	Bitewings <i>radiographs</i> - two films	No Cost
D0273	Bitewings <i>radiographs</i> - three films	No Cost
D0274	Bitewings <i>radiographs</i> - four films - <i>limited to 1 series every 6 months</i>	No Cost
D0330	Panoramic film	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	\$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 <i>cleaning</i> - adult - <i>1 per 6 month period</i>	No Cost
D1110	<i>Additional prophylaxis cleaning</i> - adult (<i>within the 6 month period</i>)	\$20.00
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 per 6 month period</i>	No Cost
D1120	<i>Additional prophylaxis cleaning</i> - child (<i>within the 6 month period</i>)	\$20.00
D1203	Topical application of fluoride - child - <i>to age 19; 1 per 6 month period</i>	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	\$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." *	
<i>- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.</i>		
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 ^{1, 2}	\$115.00
D2520	Inlay - metallic - two surfaces ^{1, 2}	\$140.00
D2530	Inlay - metallic - three or more surfaces ^{1, 2}	\$150.00
D2542	Onlay - metallic - two surfaces ^{1, 2}	\$150.00
D2543	Onlay - metallic - three surfaces ^{1, 2}	\$160.00
D2544	Onlay - metallic - four or more surfaces ^{1, 2}	\$170.00
D2710	Crown - resin-based composite (indirect) ^{1, 3}	\$170.00
D2712	Crown - $\frac{3}{4}$ resin-based composite (indirect) ^{1, 3}	\$170.00
D2720	Crown - resin with high noble metal ^{1, 3}	\$355.00
D2721	Crown - resin with predominantly base metal ^{1, 3}	\$255.00
D2722	Crown - resin with noble metal ^{1, 3}	\$255.00
D2740	Crown - porcelain/ceramic substrate ^{1, 3}	\$355.00
D2750	Crown - porcelain fused to high noble metal ^{1, 3}	\$355.00
D2751	Crown - porcelain fused to predominantly base metal ^{1, 3}	\$255.00
D2752	Crown - porcelain fused to noble metal ^{1, 3}	\$255.00
D2780	Crown - $\frac{3}{4}$ cast high noble metal ¹	\$330.00
D2781	Crown - $\frac{3}{4}$ cast predominantly base metal ¹	\$230.00
D2782	Crown - $\frac{3}{4}$ cast noble metal ¹	\$230.00
D2790	Crown - full cast high noble metal ¹	\$330.00
D2791	Crown - full cast predominantly base metal ¹	\$230.00
D2792	Crown - full cast noble metal ¹	\$230.00
D2794	Crown - titanium ¹	\$355.00
D2910	Recement inlay, onlay or partial coverage restoration	\$15.00
D2915	Recement cast or prefabricated post and core	\$15.00
D2920	Recement crown	\$15.00
D2930	Prefabricated stainless steel crown - primary tooth	\$55.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$55.00
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	\$65.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	\$55.00
D2940	Sedative filling	No Cost
D2951	Pin retention - per tooth, in addition to restoration	\$20.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> ²	\$80.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ²	\$35.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$80.00
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$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) - <i>palliative treatment only</i>	\$20.00
D2980	Crown repair, by report	\$20.00

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	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) ⁴	\$125.00

D3320	Root canal - endodontic therapy, bicuspid tooth (excluding final restoration) ⁴	\$195.00
D3330	Root canal - endodontic therapy, molar (excluding final restoration) ⁴	\$240.00
D3410	Apicoectomy/periradicular surgery - anterior ⁴	\$95.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root) ⁴	\$95.00
D3425	Apicoectomy/periradicular surgery - molar (first root) ⁴	\$95.00
D3426	Apicoectomy/periradicular surgery (each additional root) ⁴	\$60.00
D3430	Retrograde filling - per root ⁴	\$60.00
D3450	Root amputation, per root - <i>not covered in conjunction with a hemisection</i> ⁴	\$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 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
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$210.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$210.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$210.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$55.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$55.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - <i>limited to 1 treatment in any 12 consecutive months</i>	\$50.00
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	\$45.00

D5000-D5899 VI. PROSTHODONTICS (removable)

D5110	Complete denture - maxillary ^{5, 6}	\$260.00
D5120	Complete denture - mandibular ^{5, 6}	\$260.00
D5130	Immediate denture - maxillary ^{5, 6}	\$280.00
D5140	Immediate denture - mandibular ^{5, 6}	\$280.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ^{5, 6}	\$275.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ^{5, 6}	\$275.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ^{5, 6}	\$315.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ^{5, 6}	\$315.00
D5410	Adjust complete denture - maxillary ⁵	\$15.00
D5411	Adjust complete denture - mandibular ⁵	\$15.00
D5421	Adjust partial denture - maxillary ⁵	\$15.00
D5422	Adjust partial denture - mandibular ⁵	\$15.00
D5510	Repair broken complete denture base	\$15+lab
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$15+lab
	<i>Additional</i>	\$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) ⁷	\$45.00
D5731	Reline complete mandibular denture (chairside) ⁷	\$45.00
D5740	Reline maxillary partial denture (chairside) ⁷	\$45.00
D5741	Reline mandibular partial denture (chairside) ⁷	\$45.00
D5750	Reline complete maxillary denture (laboratory) ⁷	\$35+lab
D5751	Reline complete mandibular denture (laboratory) ⁷	\$35+lab

D5760	Reline maxillary partial denture (laboratory) ⁷	\$35+lab
D5761	Reline mandibular partial denture (laboratory) ⁷	\$35+lab
D5850	Tissue conditioning, maxillary ^{5, 7}	\$25.00
D5851	Tissue conditioning, mandibular ^{5, 7}	\$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 ⁸	\$330.00
D6211	Pontic - cast predominantly base metal ⁸	\$230.00
D6212	Pontic - cast noble metal ⁸	\$230.00
D6240	Pontic - porcelain fused to high noble metal ^{3, 8}	\$355.00
D6241	Pontic - porcelain fused to predominantly base metal ^{3, 8}	\$255.00
D6242	Pontic - porcelain fused to noble metal ^{3, 8}	\$255.00
D6245	Pontic - porcelain/ceramic ^{3, 8}	\$355.00
D6250	Pontic - resin with high noble metal ^{3, 8}	\$355.00
D6251	Pontic - resin with predominantly base metal ^{3, 8}	\$255.00
D6252	Pontic - resin with noble metal ^{3, 8}	\$255.00
D6720	Crown - resin with high noble metal ^{3, 8}	\$355.00
D6721	Crown - resin with predominantly base metal ^{3, 8}	\$255.00
D6722	Crown - resin with noble metal ^{3, 8}	\$255.00
D6740	Crown - porcelain/ceramic ^{3, 8}	\$355.00
D6750	Crown - porcelain fused to high noble metal ^{3, 8}	\$355.00
D6751	Crown - porcelain fused to predominantly base metal ^{3, 8}	\$255.00
D6752	Crown - porcelain fused to noble metal ^{3, 8}	\$255.00
D6780	Crown - ¾ cast high noble metal ⁸	\$330.00
D6781	Crown - ¾ cast predominantly base metal ⁸	\$230.00
D6782	Crown - ¾ cast noble metal ⁸	\$230.00
D6790	Crown - full cast high noble metal ⁸	\$330.00
D6791	Crown - full cast predominantly base metal ⁸	\$230.00
D6792	Crown - full cast noble metal ⁸	\$230.00
D6930	Recement fixed partial denture	\$20.00
D6940	Stress breaker ⁸	\$35.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - <i>includes canal preparation</i> ²	\$80.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer - <i>base metal post; includes canal preparation</i> ²	\$80.00
D6976	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ²	\$35.00
D6977	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$25.00
D6980	Fixed partial denture repair, by report	\$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 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 elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$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
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 (frenectomy or frenotomy) - separate 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 - <i>child or adolescent to age 19</i> ⁹	**
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i> ⁹	**
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including dependent adult children covered as full-time students</i> ⁹	**
D8660	Pre-orthodontic treatment visit - <i>not to be charged with any other consultation procedure(s)</i> ¹⁰	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers) ¹¹	**

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	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
D9951	Occlusal adjustment, limited	\$25.00
D9952	Occlusal adjustment, complete	\$150.00
D9999	Unspecified adjunctive procedure, by report - <i>includes failed appointment without 24 hour notice - per 15 minutes of appointment time</i>	\$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 Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.
- ² 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.
- ³ Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of \$150.00.
- ⁴ A benefit for permanent teeth only.
- ⁵ 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.
- ⁶ Replacement is subject to a limitation requiring the existing denture to be 5+ years old.
- ⁷ Limited to 1 per denture during any 12 consecutive months.

- ⁸ Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.
- ⁹ 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.
- ¹⁰ 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.
- ¹¹ Includes adjustments and/or office visits up to 24 months. After 24 months, a monthly fee of \$75.00 applies.

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. Soft tissue management programs are limited to periodontal pocket charting, root planing, scaling, curettage, oral hygiene instruction, periodontal maintenance and/or prophylaxis. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered services.
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 Workers' 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 procedure 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.

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 a Certificate of Coverage prior to enrollment, you may request a copy by calling the Customer Service department 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

Administered by:

Delta Dental Insurance Company

12898 Towne Center Drive

Cerritos, CA 90703-8546

www.deltadentalins.com



VI. DENTAL INSURANCE

**B. DELTACARE[®] USA COMPREHENSIVE MANAGED
CARE DENTAL PLAN
(PLAN FLM97)**

DeltaCare[®] USA

Welcome to DeltaCare USA

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.

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

Cost savings

- 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 except for accidental injury

Comprehensive Managed Care Plan - FLM97

The DeltaCare USA Program covers the following types of care:

- | | |
|--|---|
| ✓ Preventive
(exams, X-rays, cleaning, fluoride treatments) | ✓ Major
(onlays, crowns, dentures, bridges) |
| ✓ Basic
(extractions, root canals, oral surgery, restorations) | ✓ Orthodontia
(covered in part for children and adults) |

The Program has certain limitations and exclusions (see Limitations and Exclusions of Benefits).

When you enroll, you select a contract dentist to provide services. The DeltaCare network consists of private practice dental facilities that have been carefully screened for quality.

- | | |
|---|--|
| ✓ Comprehensive benefits for you and your family. | ✓ No deductibles or annual dollar maximum on basic benefits. |
| ✓ No restrictions on pre-existing conditions, except for work in progress. | <i>In our plan there are no deductibles to pay on basic benefits, so your benefits begin immediately.</i> |
| ✓ Large, stable network of dentists, so you can enjoy a long-term relationship with your dentist. | ✓ Out-of-pocket costs are clearly defined. |
| ✓ Delta Dental maintains quality standards by visiting each contract dental facility every three months. | ✓ Out-of-area dental emergency coverage up to \$100 per emergency. |
| ✓ No claim forms to complete.
<i>A predetermined copayment schedule eliminates the need for claim forms.</i> | ✓ No annual dollar maximum except for accidental injury. |
| ✓ Specialists services. | <i>The DeltaCare program provides coverage for accidental injury (caused by external forces) at 100% of the filed fees for benefits (less any applicable copayments). The enrollee must be eligible under the DeltaCare program when the accident occurs. Accidental injury benefits are subject to a \$1600 maximum, per 12 months, per person.</i> |
| ✓ Expanded business hours for toll-free customer service, from 8 a.m. to 9 p.m., Eastern Time. | |

Easy Enrollment

School Board of Orange County employees have the choice of either the Basic Managed Care Plan FLM12 or the Comprehensive Managed Care Plan FLM97. Please be sure to read all the information contained in the booklets.

Next, review the list of managed care dental facilities. You and your eligible dependents may receive care from the same contract dentist, or you may select up to a maximum of three contract dentists to meet your family's needs.

Once you have made all of your choices, simply complete the enrollment process as directed by your benefits administrator.

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 web site (www.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 have worked in dental facilities and 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-2009 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.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
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
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral <i>radiographs</i> - complete series (including bitewings) - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0270	Bitewing <i>radiograph</i> - single film	No Cost
D0272	Bitewings <i>radiographs</i> - two films	No Cost
D0273	Bitewings <i>radiographs</i> - three films	No Cost
D0274	Bitewings <i>radiographs</i> - four films - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 films	No Cost
D0330	Panoramic film	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
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	\$5.00
D1000-D1999	II. PREVENTIVE - (When services are provided by a Contract Specialist, the Enrollee pays the copayment noted) *	
D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 per 6 month period</i>	No Cost
D1110	<i>Additional prophylaxis cleaning</i> - adult (<i>within the 6 month period</i>)	\$15.00
D1120	Prophylaxis <i>cleaning</i> - child - <i>1 per 6 month period</i>	No Cost
D1120	<i>Additional prophylaxis cleaning</i> - child (<i>within the 6 month period</i>)	\$15.00
D1203	Topical application of fluoride - child - <i>to age 19; 1 per 6 month period</i>	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	\$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-cementation of 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 - $\frac{3}{4}$ 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 - $\frac{3}{4}$ cast high noble metal	\$295.00
D2781	Crown - $\frac{3}{4}$ cast predominantly base metal	\$195.00
D2782	Crown - $\frac{3}{4}$ 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	Recement inlay, onlay or partial coverage restoration	\$10.00
D2915	Recement cast or prefabricated post and core	\$10.00
D2920	Recement crown	\$10.00
D2930	Prefabricated stainless steel crown - primary tooth	\$45.00

D2931	Prefabricated stainless steel crown - permanent tooth	\$45.00
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	\$55.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	\$45.00
D2940	Sedative filling	\$15.00
D2950	Core buildup, including any pins	\$40.00
D2951	Pin retention - per tooth, in addition to restoration	\$12.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	\$90.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	\$35.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$75.00
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$25.00
D2970	Temporary crown (fractured tooth) - <i>palliative treatment only</i>	\$20.00
D2980	Crown repair, by report	\$20.00

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	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$80.00
D3320	<i>Root canal</i> - endodontic therapy, bicuspid tooth (excluding final restoration)	\$140.00
D3330	<i>Root canal</i> - 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/periradicular surgery - anterior	\$95.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$95.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	\$95.00
D3426	Apicoectomy/periradicular surgery (each additional root)	\$50.00
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 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
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$300.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$300.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$45.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	\$45.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - <i>limited to 1 treatment in any 12 consecutive months</i>	\$35.00
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	\$45.00
D4910	<i>Additional periodontal maintenance (within the 6 month period)</i>	\$65.00

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 - $\frac{3}{4}$ cast high noble metal	\$295.00
D6781	Crown - $\frac{3}{4}$ cast predominantly base metal	\$195.00
D6782	Crown - $\frac{3}{4}$ 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	Recement fixed partial denture	\$10.00
D6940	Stress breaker	\$35.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - <i>includes canal preparation</i>	\$90.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer - <i>base metal post; includes canal preparation</i>	\$75.00
D6973	Core buildup for retainer, including any pins	\$55.00
D6976	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	\$35.00
D6977	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$25.00
D6980	Fixed partial denture repair, by report	\$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 local anesthetic.

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7111	Extraction, coronal remnants - deciduous tooth (<i>each additional</i>)	\$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) (<i>each additional</i>)	\$5.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$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
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 (frenectomy or frenotomy) - separate 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 (including bitewings)

D0322 Tomographic survey

D0330 Panoramic film

D0340 Cephalometric film

D0350 Oral/facial photographic images

D0470 Diagnostic casts

The benefit for post-treatment records includes: \$120.00

D0210 Intraoral - complete series (including bitewings)

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 visit \$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 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 conscious sedation/analgesia - first 30 minutes \$195.00

D9242 Intravenous 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

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

D9972 External bleaching - per arch - *limited to one bleaching tray and gel for two weeks of self treatment* \$125.00

D9999 Unspecified adjunctive procedure, by report - *includes failed 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 D9972, External bleaching, 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 procedure 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.

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 a Certificate of Coverage prior to enrollment, you may request a copy by calling the Customer Service department 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

Administered by:

Delta Dental Insurance Company

12898 Towne Center Drive

Cerritos, CA 90703-8546

www.deltadentalins.com



VI. DENTAL INSURANCE

**C. DELTA DENTAL PPO DENTAL PLAN
(PREFERRED PROVIDER ORGANIZATION)**

Plan Benefit Highlights for: ORANGE COUNTY PUBLIC SCHOOLS**Group No: 01552****Effective Date: 10/1/2010**

Eligibility	Primary enrollee, spouse and eligible dependent children to age 25		
Deductibles	In-Network \$25 per person, \$75 per family, per calendar year Out-of-Network \$50 per person, \$150 per family, per calendar year		
Deductibles waived for D & P?	Yes		
Maximums	\$1,250 per person		
D & P counts toward maximum?	No		
Waiting Period(s)	Basic Benefits 0 Months	Major Benefits 0 Months	Orthodontics 0 Months

Benefits and Covered Services*	In-PPO Network**	Out-of-PPO Network**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays, fluoride treatment, space maintainers, sealants	100 %	80 %
Basic Services Fillings	80 %	60 %
Endodontics (root canals) Covered Under Basic Services	80 %	60 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	60 %
Oral Surgery Incisions, excisions, surgical removal of tooth Covered Under Basic Services	80 %	60 %
Major Services Crowns, inlays, onlays, cast restorations, bridges, dentures, denture repairs, Major Endodontics, Major Periodontics	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 in-network dentists, PPO contracted fees for out-of-network dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily each dentist's actual fees.

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Customer Service
800-521-2651

Claims Address
P.O. Box 1809
Alpharetta, GA 30023-1809

www.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 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 \$1,250 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.

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.



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PROCEDURE		Maximum* Allowable Charge	Maximum Reimbursement** In Network	Maximum Reimbursement** Out of Network
DIAGNOSTIC (Deductible does not apply)				
Clinical Oral Evaluations				
D0120	Periodic oral evaluation	\$24.00	\$24.00	\$19.20
D0140	Limited oral evaluation – problem focused	\$38.00	\$38.00	\$30.40
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 <i>(limited to one per patient per dentist, all other evaluations will be benefited as D0120)</i>	\$39.00	\$39.00	\$31.20
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$62.00	\$62.00	\$49.60
D0180	Comprehensive periodontal evaluation - new or established patient <i>(limited to one per patient per dentist, all other evaluations will be benefited as D0120)</i>	\$47.00	\$47.00	\$37.60
Radiographs/Diagnostic Imaging (Including Interpretation) <i>(Any combination of bitewings, periapicals, and panoramic films taken on the same day will be combined as a complete series)</i> (Deductible does not apply)				
D0210	Intraoral - complete series (including bitewings)	\$72.00	\$72.00	\$57.60
D0220	Intraoral - periapical first film	\$14.00	\$14.00	\$11.20
D0230	Intraoral – periapical each additional film	\$11.00	\$11.00	\$8.80
D0240	Intraoral – occlusal film	\$20.00	\$20.00	\$16.00
D0250	Extraoral – first film	\$22.00	\$22.00	\$17.60
D0260	Extraoral – each additional film	\$19.00	\$19.00	\$15.20
D0270	Bitewing – single film	\$14.00	\$14.00	\$11.20
D0272	Bitewings – two films	\$20.00	\$20.00	\$16.00
D0273	Bitewings – three films	\$26.00	\$26.00	\$20.80
D0274	Bitewings – four films	\$31.00	\$31.00	\$24.80
D0277	Vertical bitewings - 7 to 8 films	\$36.00	\$36.00	\$28.80
D0330	Panoramic film	\$63.00	\$63.00	\$50.40
D0340	Cephalometric film	\$64.00	\$64.00	\$51.20
D0350	Oral/facial photographic images	\$33.00	\$33.00	\$26.40
Tests and Examinations (Deductible does not apply)				
D0460	Pulp vitality tests <i>(benefit once per visit only in conjunction with an emergency exam)</i>	\$24.00	\$24.00	\$19.20
D0470	Diagnostic casts	\$54.00	\$54.00	\$43.20
Oral Pathology Laboratory (Deductible does not apply)				
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$53.00	\$53.00	\$42.40
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$84.00	\$84.00	\$67.20
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$94.00	\$94.00	\$75.20
PREVENTIVE (Deductible does not apply)				
Dental Prophylaxis				
D1110	Prophylaxis – adult	\$53.00	\$53.00	\$42.40
D1120	Prophylaxis - child <i>(under age 14)</i>	\$35.00	\$35.00	\$28.00
Topical Fluoride Treatment (Office Procedure) (Deductible does not apply)				
D1203	Topical application of fluoride -child	\$18.00	\$18.00	\$14.40
D1204	Topical application of fluoride - adult	\$19.00	\$19.00	\$15.20
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	\$19.00	\$19.00	\$15.20

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PROCEDURE		Maximum* Allowable Charge	Maximum Reimbursement** In Network	Maximum Reimbursement** Out of Network
Other Preventive Services (Deductible does not apply)				
D1351	Sealant - per tooth <i>(includes any necessary repair or replacement within two years)</i>	\$27.00	\$27.00	\$21.60
Space Maintenance (Passive Appliances) (Deductible does not apply)				
D1510	Space maintainer –fixed – unilateral	\$171.00	\$171.00	\$136.80
D1515	Space maintainer – fixed – bilateral	\$275.00	\$275.00	\$220.00
D1520	Space maintainer – removable – unilateral	\$204.00	\$204.00	\$163.20
D1525	Space maintainer – removable – bilateral	\$276.00	\$276.00	\$220.80
D1550	Re-cementation of space maintainer	\$41.00	\$41.00	\$32.80
D1555	Removal of fixed space maintainer	\$41.00	\$41.00	\$32.80
RESTORATIVE				
Amalgam Restorations (Including Polishing)				
D2140	Amalgam – one surface, primary or permanent	\$65.00	\$52.00	\$39.00
D2150	Amalgam – two surfaces, primary or permanent	\$82.00	\$65.60	\$49.20
D2160	Amalgam – three surfaces, primary or permanent	\$98.00	\$78.40	\$58.80
D2161	Amalgam – four or more surfaces, primary or permanent	\$118.00	\$94.40	\$70.80
Resin-Based Composite Restorations - Direct				
D2330	Resin-based composite – one surface, anterior	\$75.00	\$60.00	\$45.00
D2331	Resin-based composite – two surfaces, anterior	\$92.00	\$73.60	\$55.20
D2332	Resin-based composite – three surfaces, anterior	\$114.00	\$91.20	\$68.40
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$139.00	\$111.20	\$83.40
D2390	Resin-based composite crown, anterior	\$173.00	\$138.40	\$103.80
D2391	Resin-based composite - one surface, posterior	\$84.00	\$67.20	\$50.40
D2392	Resin-based composite - two surfaces, posterior	\$109.00	\$87.20	\$65.40
D2393	Resin-based composite - three surfaces, posterior	\$138.00	\$110.40	\$82.80
D2394	Resin-based composite - four or more surfaces, posterior	\$164.00	\$131.20	\$98.40
Inlay/Onlay Restorations				
D2510	Inlay – metallic – one surface	\$411.00	\$205.50	\$164.40
D2520	Inlay – metallic – two surfaces	\$460.00	\$230.00	\$184.00
D2530	Inlay – metallic – three or more surfaces	\$495.00	\$247.50	\$198.00
D2542	Onlay – metallic – two surfaces	\$510.00	\$255.00	\$204.00
D2543	Onlay – metallic – three surfaces	\$581.00	\$290.50	\$232.40
D2544	Onlay – metallic – four or more surfaces	\$592.00	\$296.00	\$236.80
Crowns - Single Restorations Only				
D2710	Crown – resin-based composite (indirect)	\$323.00	\$161.50	\$129.20
D2712	Crown – 3/4 resin-based composite (indirect)	\$323.00	\$161.50	\$129.20
D2720	Crown – resin with high noble metal	\$561.00	\$280.50	\$224.40
D2721	Crown – resin with predominantly base metal	\$487.00	\$243.50	\$194.80
D2722	Crown – resin with noble metal	\$510.00	\$255.00	\$204.00
D2740	Crown – porcelain/ceramic substrate	\$765.00	\$382.50	\$306.00
D2750	Crown – porcelain fused to high noble metal	\$740.00	\$370.00	\$296.00
D2751	Crown – porcelain fused to predominantly base metal	\$612.00	\$306.00	\$244.80
D2752	Crown – porcelain fused to noble metal	\$638.00	\$319.00	\$255.20
D2780	Crown – 3/4 cast high noble metal	\$591.00	\$295.50	\$236.40
D2781	Crown – 3/4 cast predominantly base metal	\$573.00	\$286.50	\$229.20
D2782	Crown – 3/4 cast noble metal	\$581.00	\$290.50	\$232.40
D2783	Crown – 3/4 porcelain/ceramic	\$596.00	\$298.00	\$238.40
D2790	Crown – full cast high noble metal	\$638.00	\$319.00	\$255.20
D2791	Crown – full cast predominantly base metal	\$561.00	\$280.50	\$224.40
D2792	Crown – full cast noble metal	\$612.00	\$306.00	\$244.80

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PROCEDURE		Maximum* Allowable Charge	Maximum Reimbursement** In Network	Maximum Reimbursement** Out of Network
D2794	Crown – titanium	\$638.00	\$319.00	\$255.20
Other Restorative Services				
D2910	Recement inlay, onlay, or partial coverage restoration	\$51.00	\$40.80	\$30.60
D2915	Recement cast or prefabricated post and core	\$51.00	\$40.80	\$30.60
D2920	Recement crown	\$52.00	\$41.60	\$31.20
D2930	Prefabricated stainless steel crown – primary tooth	\$139.00	\$69.50	\$55.60
D2931	Prefabricated stainless steel crown – permanent tooth	\$165.00	\$82.50	\$66.00
D2932	Prefabricated resin crown	\$173.00	\$86.50	\$69.20
D2933	Prefabricated stainless steel crown with resin window	\$193.00	\$96.50	\$77.20
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$193.00	\$96.50	\$77.20
D2940	Sedative filling	\$57.00	\$45.60	\$34.20
D2950	Core build-up, including any pins	\$137.00	\$68.50	\$54.80
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	\$203.00	\$101.50	\$81.20
D2954	Prefabricated post and core in addition to crown	\$163.00	\$81.50	\$65.20
D2960	Labial veneer (resin laminate) – chairside	\$298.00	\$149.00	\$119.20
D2961	Labial veneer (resin laminate) – laboratory	\$494.00	\$247.00	\$197.60
D2962	Labial veneer (porcelain laminate) – laboratory	\$543.00	\$271.50	\$217.20
ENDODONTICS				
Pulpotomy				
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$108.00	\$86.40	\$64.80
D3221	Pulpal debridement, primary and permanent teeth	\$120.00	\$96.00	\$72.00
Endodontic Therapy of Primary Teeth				
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$151.00	\$120.80	\$90.60
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$163.00	\$130.40	\$97.80
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care)				
D3310	Endodontic therapy - anterior tooth (excluding final restoration)	\$434.00	\$347.20	\$260.40
D3320	Endodontic therapy - bicuspid tooth (excluding final restoration)	\$510.00	\$408.00	\$306.00
D3330	Endodontic therapy - molar tooth (excluding final restoration)	\$663.00	\$530.40	\$397.80
D3332	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	B/R	B/R	B/R
D3333	Internal root repair of perforation defects	\$120.00	\$96.00	\$72.00
Endodontic Retreatment				
D3346	Retreatment of previous root canal therapy – anterior	\$490.00	\$392.00	\$294.00
D3347	Retreatment of previous root canal therapy – bicuspid	\$560.00	\$448.00	\$336.00
D3348	Retreatment of previous root canal therapy – molar	\$688.00	\$550.40	\$412.80
Apexification/Recalcification Procedures				
D3351	Apexification/recalcification/pulpal regeneration – initial visit (apical closure/ calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$191.00	\$152.80	\$114.60
D3352	Apexification/recalcification/pulpal regeneration – interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$125.00	\$100.00	\$75.00
D3353	Apexification/recalcification – final visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$291.00	\$232.80	\$174.60
Apicoectomy/Periradicular Services				
D3410	Apicoectomy/periradicular surgery – anterior	\$412.00	\$206.00	\$164.80
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	\$443.00	\$221.50	\$177.20

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PROCEDURE		Maximum* Allowable Charge	Maximum Reimbursement** In Network	Maximum Reimbursement** Out of Network
D3425	Apicoectomy/periradicular surgery – molar (first root)	\$539.00	\$269.50	\$215.60
D3426	Apicoectomy/periradicular surgery (each additional root)	\$194.00	\$97.00	\$77.60
D3430	Retrograde filling – per root	\$128.00	\$64.00	\$51.20
D3450	Root amputation – per root	\$288.00	\$144.00	\$115.20
Other Endodontic Procedures				
D3920	Hemisection (including any root removal), not including root canal therapy	\$253.00	\$202.40	\$151.80
PERIODONTICS				
Surgical Services (Including Usual Postoperative Care)				
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	\$326.00	\$163.00	\$130.40
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$196.00	\$98.00	\$78.40
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$398.00	\$199.00	\$159.20
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$282.00	\$141.00	\$112.80
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$583.00	\$291.50	\$233.20
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$408.00	\$204.00	\$163.20
D4263	Bone replacement graft - first site in quadrant (<i>separate fee is not allowed with oral surgery or endodontic procedure</i>)	\$224.00	\$112.00	\$89.60
D4264	Bone replacement graft - each additional site in quadrant (<i>separate fee is not allowed with oral surgery or endodontic procedure</i>)	\$215.00	\$107.50	\$86.00
D4266	Guided tissue regeneration - resorbable barrier, per site	\$408.00	\$204.00	\$163.20
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	\$430.00	\$215.00	\$172.00
D4270	Pedicle soft tissue graft procedure (<i>limited to two sites per quadrant</i>)	\$451.00	\$225.50	\$180.40
D4271	Free soft tissue graft procedure (including donor site surgery) (<i>limited to two sites per quadrant</i>)	\$469.00	\$234.50	\$187.60
D4273	Subepithelial connective tissue graft procedures, per tooth (<i>limited to two sites per quadrant</i>)	\$581.00	\$290.50	\$232.40
Non-Surgical Periodontal Service				
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$124.00	\$99.20	\$74.40
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	\$85.00	\$68.00	\$51.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$53.00	\$26.50	\$21.20
Other Periodontal Services				
D4910	Periodontal maintenance	\$68.00	\$34.00	\$27.20
PROSTHODONTICS (Removable)				
Complete Dentures (Including Routine Post-Delivery Care) (<i>includes routine post-delivery care for the first six months after placement</i>)				
D5110	Complete denture – maxillary	\$842.00	\$421.00	\$336.80
D5120	Complete denture – mandibular	\$842.00	\$421.00	\$336.80
D5130	Immediate denture – maxillary	\$918.00	\$459.00	\$367.20
D5140	Immediate denture – mandibular	\$918.00	\$459.00	\$367.20
Partial Dentures (Including Routine Post-Delivery Care) (<i>includes routine post-delivery care for the first six months after placement</i>)				
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$663.00	\$331.50	\$265.20
D5212	Mandibular partial denture – resin base (including any conventional	\$663.00	\$331.50	\$265.20

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PROCEDURE		Maximum* Allowable Charge	Maximum Reimbursement** In Network	Maximum Reimbursement** Out of Network
	clasps, rests and teeth)			
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$944.00	\$472.00	\$377.60
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$944.00	\$472.00	\$377.60
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	\$708.00	\$354.00	\$283.20
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	\$708.00	\$354.00	\$283.20
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	\$574.00	\$287.00	\$229.60
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	\$103.00	\$51.50	\$41.20
D5520	Replace missing or broken teeth – complete denture (each tooth)	\$82.00	\$41.00	\$32.80
Repairs to Partial Dentures				
D5610	Repair resin denture base	\$84.00	\$67.20	\$50.40
D5630	Repair or replace broken clasp	\$122.00	\$97.60	\$73.20
D5640	Replace broken teeth – per tooth	\$82.00	\$65.60	\$49.20
D5650	Add tooth to existing partial denture	\$99.00	\$49.50	\$39.60
D5660	Add clasp to existing partial denture	\$122.00	\$61.00	\$48.80
Denture Rebase Procedures				
D5710	Rebase complete maxillary denture	\$276.00	\$138.00	\$110.40
D5711	Rebase complete mandibular denture	\$276.00	\$138.00	\$110.40
D5720	Rebase maxillary partial denture	\$264.00	\$132.00	\$105.60
D5721	Rebase mandibular partial denture	\$264.00	\$132.00	\$105.60
Denture Reline Procedures				
D5730	Reline complete maxillary denture (chairside)	\$170.00	\$85.00	\$68.00
D5731	Reline complete mandibular denture (chairside)	\$170.00	\$85.00	\$68.00
D5740	Reline maxillary partial denture (chairside)	\$172.00	\$86.00	\$68.80
D5741	Reline mandibular partial denture (chairside)	\$172.00	\$86.00	\$68.80
D5750	Reline complete maxillary denture (laboratory)	\$228.00	\$114.00	\$91.20
D5751	Reline complete mandibular denture (laboratory)	\$228.00	\$114.00	\$91.20
D5760	Reline maxillary partial denture (laboratory)	\$221.00	\$110.50	\$88.40
D5761	Reline mandibular partial denture (laboratory)	\$221.00	\$110.50	\$88.40
Interim Prosthesis				
D5820	Interim partial denture (maxillary)	\$323.00	\$161.50	\$129.20
D5821	Interim partial denture (mandibular)	\$323.00	\$161.50	\$129.20
Other Removable Prosthetic Services				
D5850	Tissue conditioning, maxillary	\$87.00	\$43.50	\$34.80
D5851	Tissue conditioning, mandibular	\$87.00	\$43.50	\$34.80
PROSTHODONTICS, FIXED				
Fixed Partial Denture Pontics				
D6210	Pontic – cast high noble metal	\$568.00	\$284.00	\$227.20

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D6211	Pontic – cast predominantly base metal	\$503.00	\$251.50	\$201.20
D6212	Pontic – cast noble metal	\$536.00	\$268.00	\$214.40
D6214	Pontic – titanium	\$568.00	\$284.00	\$227.20
D6240	Pontic – porcelain fused to high noble metal	\$646.00	\$323.00	\$258.40
D6241	Pontic – porcelain fused to predominantly base metal	\$561.00	\$280.50	\$224.40
D6242	Pontic – porcelain fused to noble metal	\$603.00	\$301.50	\$241.20
D6250	Pontic – resin with high noble metal	\$530.00	\$265.00	\$212.00
D6251	Pontic – resin with predominantly base metal	\$494.00	\$247.00	\$197.60
D6252	Pontic – resin with noble metal	\$516.00	\$258.00	\$206.40
Fixed Partial Denture Retainers - Inlays/Onlays				
D6545	Retainer – cast metal for resin bonded fixed prosthesis	\$334.00	\$167.00	\$133.60
D6602	Inlay - cast high noble metal, two surfaces			
D6603	Inlay - cast high noble metal, three or more surfaces	\$555.00	\$277.50	\$222.00
D6604	Inlay - cast predominantly base metal, two surfaces	\$511.00	\$255.50	\$204.40
D6605	Inlay - cast predominantly base metal, three or more surfaces	\$545.00	\$272.50	\$218.00
D6606	Inlay - cast noble metal, two surfaces	\$514.00	\$257.00	\$205.60
D6607	Inlay - cast noble metal, three or more surfaces	\$550.00	\$275.00	\$220.00
D6610	Onlay - cast high noble metal, two surfaces	\$638.00	\$319.00	\$255.20
D6611	Onlay - cast high noble metal, three or more surfaces	\$648.00	\$324.00	\$259.20
D6612	Onlay - cast predominantly base metal, two surfaces	\$577.00	\$288.50	\$230.80
D6613	Onlay - cast predominantly base metal, three or more surfaces	\$586.00	\$293.00	\$234.40
D6614	Onlay - cast noble metal, two surfaces	\$586.00	\$293.00	\$234.40
D6615	Onlay - cast noble metal, three or more surfaces	\$595.00	\$297.50	\$238.00
D6624	Inlay - titanium	\$555.00	\$277.50	\$222.00
D6634	Onlay - titanium	\$648.00	\$324.00	\$259.20
Fixed Partial Denture Retainers - Crowns				
D6720	Crown—resin with high noble metal	\$561.00	\$280.50	\$224.40
D6721	Crown—resin with predominantly base metal	\$487.00	\$243.50	\$194.80
D6722	Crown—resin with noble metal	\$510.00	\$255.00	\$204.00
D6750	Crown – porcelain fused to high noble metal	\$740.00	\$370.00	\$296.00
D6751	Crown – porcelain fused to predominantly base metal	\$612.00	\$306.00	\$244.80
D6752	Crown – porcelain fused to noble metal	\$638.00	\$319.00	\$255.20
D6780	Crown – ½ cast high noble metal	\$591.00	\$295.50	\$236.40
D6781	Crown -3/4 cast predominantly base metal	\$573.00	\$286.50	\$229.20
D6782	Crown - 3/4 cast noble metal	\$581.00	\$290.50	\$232.40
D6790	Crown – full cast high noble metal	\$638.00	\$319.00	\$255.20
D6791	Crown – full cast predominantly base metal	\$561.00	\$280.50	\$224.40
D6792	Crown – full cast noble metal	\$612.00	\$306.00	\$244.80
D6794	Crown - titanium	\$638.00	\$319.00	\$255.20
Other Fixed Partial Denture Services				
D6930	Recement fixed partial denture	\$76.00	\$60.80	\$45.60
D6940	Stress breaker	\$191.00	\$95.50	\$76.40
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$209.00	\$104.50	\$83.60
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$166.00	\$83.00	\$66.40
D6973	Core build-up for retainer, including any pins	\$134.00	\$67.00	\$53.60
ORAL AND MAXILLOFACIAL SURGERY				
Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)				
D7111	Extraction, coronal remnants - deciduous tooth	\$59.00	\$47.20	\$35.40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$80.00	\$64.00	\$48.00

* 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.



Delta Dental PPO Schedule of Benefits
Orlando, Tampa, & St. Petersburg Areas Only
Covering Zip Codes 327, 328, 335 - 337, 342, 346, 347

PROCEDURE		Maximum* Allowable Charge	Maximum Reimbursement** In Network	Maximum Reimbursement** Out of Network
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	\$136.00	\$108.80	\$81.60
D7220	Removal of impacted tooth – soft tissue	\$171.00	\$136.80	\$102.60
D7230	Removal of impacted tooth – partially bony	\$213.00	\$170.40	\$127.80
D7240	Removal of impacted tooth – completely bony	\$256.00	\$204.80	\$153.60
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$148.00	\$118.40	\$88.80
Other Surgical Procedures				
D7260	Oroantral fistula closure	\$582.00	\$465.60	\$349.20
D7261	Primary closure of a sinus perforation	\$582.00	\$465.60	\$349.20
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$261.00	\$208.80	\$156.60
D7283	Placement of device to facilitate eruption of impacted tooth	B/R	B/R	B/R
D7285	Biopsy of oral tissue—hard (bone, tooth)	\$214.00	\$171.20	\$128.40
D7286	Biopsy of oral tissue—soft	\$163.00	\$130.40	\$97.80
Alveoloplasty - Surgical Preparation of Ridge for Dentures				
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$153.00	\$122.40	\$91.80
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$92.00	\$73.60	\$55.20
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$228.00	\$182.40	\$136.80
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$137.00	\$109.60	\$82.20
Vestibuloplasty				
D7340	Vestibuloplasty—ridge extension (secondary epithelization)	\$408.00	\$326.40	\$244.80
D7350	Vestibuloplasty—ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$455.00	\$364.00	\$273.00
Surgical Excision of Soft Tissue Lesions				
D7410	Excision of benign lesion up to 1.25 cm	\$231.00	\$184.80	\$138.60
D7411	Excision of benign lesion greater than 1.25 cm	\$362.00	\$289.60	\$217.20
Surgical Excision of Intra-Osseous Lesions				
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$316.00	\$252.80	\$189.60
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	\$382.00	\$305.60	\$229.20
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$299.00	\$239.20	\$179.40
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25cm	\$382.00	\$305.60	\$229.20
Excision of Bone Tissue				
D7471	Removal of lateral exostosis (maxilla or mandible)	\$491.00	\$392.80	\$294.60
Surgical Incision				
D7510	Incision and drainage of abscess – intraoral soft tissue	\$120.00	\$96.00	\$72.00
D7520	Incision and drainage of abscess - extraoral soft tissue	\$170.00	\$136.00	\$102.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$158.00	\$126.40	\$94.80

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Delta Dental PPO Schedule of Benefits
Orlando, Tampa, & St. Petersburg Areas Only
Covering Zip Codes 327, 328, 335 - 337, 342, 346, 347

PROCEDURE		Maximum* Allowable Charge	Maximum Reimbursement** In Network	Maximum Reimbursement** Out of Network
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$296.00	\$236.80	\$177.60
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$269.00	\$215.20	\$161.40
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$570.00	\$456.00	\$342.00
Other Repair Procedures				
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another	\$255.00	\$204.00	\$153.00
D7970	Excision of hyperplastic tissue – per arch	\$256.00	\$204.80	\$153.60
D7971	Excision of pericoronal gingiva	\$119.00	\$95.20	\$71.40
ADJUNCTIVE GENERAL SERVICES				
Unclassified Treatment				
D9110	Palliative (emergency) treatment of dental pain - minor procedure (Deductible does not apply)	\$53.00	\$53.00	\$42.40
Anesthesia				
D9220	Deep sedation/general anesthesia - first 30 minutes	\$212.00	\$169.60	\$127.20
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$73.00	\$58.40	\$43.80
D9241	Intravenous conscious sedation/analgesia—first 30 minutes	\$227.00	\$181.60	\$136.20
D9242	Intravenous conscious sedation/analgesia—each additional 15 minutes	\$65.00	\$52.00	\$39.00
Professional Consultation				
D9310	Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)	\$58.00	\$29.00	\$23.20
Miscellaneous Services				
D9930	Treatment of complications (post-surgical)—unusual circumstances, by report	\$67.00	\$53.60	\$40.20

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 2/09/07 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.

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 is also available for your spouse 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:

- Extended exam to fit contact lenses
- 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

The LASIK and PRK procedures are available for plan members who are nearsighted or have astigmatism and wear glasses or contacts. They have contracted with many facilities and eye doctors to offer these procedures at reduced fees. The network of centers features all TLC Laser Center (TLC Vision) facilities as well as many

independent laser centers. Members receive benefits when services are received from a TLC Vision network provider with the following preferred rates:

- Silver Package: \$895/eye for Conventional LASIK
- Gold Package: \$1,295/eye for Custom LASIK. PRK is available on this package only. TLC Lifetime Commitment can be purchased, \$200 (per eye).
- Platinum Package: \$1,895/eye for Custom LASIK plus Bladeless LASIK (using IntraLase technology). Includes the TLC Lifetime Commitment.

Members must call Customer Care at 1.800.865.3676 to initiate services. If a member chooses another participating LASIK location, the member will receive a 10% discount from the provider and pay no more than \$1,800 per eye for the Conventional LASIK procedure and \$2,300 per eye for Custom LASIK.

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 (up to plan limits, less copayments)	Non-Network Doctor (maximum reimbursement, less copayments)
Eye Exam*	Paid in Full	\$ 30
Lenses (per pair)		
Single	Paid in Full	\$ 20
Bifocal	Paid in Full	\$ 40
Trifocal	Paid in Full	\$ 60
Lenticular	Paid in Full	\$100
Frame	Paid in Full	\$ 50
Contact Lenses		
Elective (Fitting + lenses)	Exam + \$125	Exam + \$125
Medically necessary**	Paid in Full	\$150
<p>*Complete vision exam per Department of Professional Regulation rule 21Q-3.07.</p> <p>**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. This 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.</p>		

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 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;
- 2) your child;
 - a) from birth to age 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, 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 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.

ADDITIONAL FORMS TO COMPLETE

None

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 and FSAs offer a unique way to help pay for health care expenses not covered by your health plan, as well as the expense of dependent care while you are working.

On 3/30/10, new legislation was passed in the Health Care Reform bill stating over-the-counter medicines and drugs will no longer be eligible for reimbursement through a health flexible spending account after 12/31/10 unless you have a prescription from your doctor.

A Flexible Spending Account is one of the only tax advantages available to individuals in any tax bracket.

DEBIT CARD

Get instant access to your FSA election.

Once you have elected into the plan, you will automatically receive a Claim Card that is pre-loaded with your annual election for your Medical FSA and/or your Dependent Care FSA.

What is the advantage of a debit card for claims payment?

The debit card provides payment convenience for you. At the point of sale, whether you are at a pharmacy or a physicians' office, you will have the ability to instantly access your FSA funds by utilizing your debit 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 debit 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) in order to maintain favorable tax treatment of your contributions to the plan. Following are some of the stipulations that you should be aware of:

- The debit card only will work at qualified medical/dependent care facilities as well as certain pharmacies and grocery stores. The debit card will NOT work at gas stations, restaurants, clothing stores and 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 from any transaction in which you may have used the debit card that TASC cannot identify 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 debit card.
- **You still will need to save all of your receipts in case you are contacted by TASC to provide more detail about a specific transaction.**
- Should you use your debit card and not be able to provide/produce a requested receipt, the IRS allows TASC to block your debit card for future use until you can either produce a receipt for the transaction in question or you have paid back the plan for the transaction in question.
- Should you accidentally use your 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 debit 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 does allow for TASC to issue you a 1099 form (i.e. reported as income) in the amount of the expense in question.

How do you use the Debit Card?

The debit card is a MasterCard debit card and works just like any other bank card that you may have. 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.

Can my spouse use the Debit Card?

Once you enroll in the FSA, you will receive a welcome kit from TASC that will include an application for a debit card for one additional dependent – spouse or child. This additional debit card will be supplied at no additional cost to you.

PLAN YEAR

In order to make your funds available to you as they are deducted from your paycheck, the plan year for flexible spending accounts 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 2011-12 Plan Year (August 31, 2012) for a Medical Expense FSA. This new grace period ends on November 15, 2012. During the grace period, you may incur expenses and submit claims for these expenses. Funds will be automatically deducted from any remaining dollars in your 2011-12 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, 2012. This is a period for filing claims incurred anytime during the 2011-12 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, 2012. 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, 2012, against the 2011-12 Plan Year.

Remember that for your 2011-12 Flexible Spending Accounts you will have until November 30, 2012, to submit receipts for reimbursement.

The IRS requires FSA customers to maintain complete documentation, including keeping 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 Flexible Spending Account (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 \$5,000. 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 (\$3650 for 2010);
- have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year **or**
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

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

On 3/30/10, new legislation was passed in the Health Care Reform bill stating over-the-counter medicines and drugs will no longer be eligible for reimbursement through a health flexible spending account after 12/31/10 unless you have a prescription from your doctor. Please note the eligible list below contains over-the-counter items that may or may not be eligible after 12/31/10.

Examples of Medical Expenses Eligible for Reimbursement*

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

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

On 3/30/10, new legislation was passed in the Health Care Reform bill stating over-the-counter medicines and drugs will no longer be eligible for reimbursement through a health flexible spending account after 12/31/10 unless you have a prescription from your doctor. Please note the eligible list below contains over-the-counter items that may or may not be eligible after 12/31/10.

Your Over-the-Counter (OTC) items, medicines and drugs may be reimbursable through your Medical Expense FSA. Save valuable tax dollars on certain categories of OTC items, medicines and drugs, such as: allergy treatments, antacids, cold remedies, first-aid supplies and pain relievers.

You may be reimbursed for OTCs 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.

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

Examples of OTC Items Eligible for Reimbursement

Antacids, allergy medicine, pain reliever, cold medicine, anti-diarrhea 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, eye drops, hemorrhoid creams, motion sickness pills, bandages, rubbing alcohol, pregnancy test kits, thermometers, condoms, spermicidal foam, incontinence supplies, nasal strips, etc.

Examples of OTC Items Not Eligible for Reimbursement

Toothpaste, lip moisturizer, face cream, daily vitamins, suntan lotion, etc.

NOTE: Dual Purpose Products (need statement from licensed medical practitioner)

Calcium, vitamins, weight loss drugs, sunscreen, acne treatment, St. John's Wart, fiber supplements, etc.

B. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care Flexible Spending Account 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:

- The dependent is under age 13 (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
- are 13 years old or younger and
- 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](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 must also 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, if your adjusted gross income is greater than \$14,000, (families with a combined taxable income of more than \$24,000 a year) you would probably receive a greater tax break using the Dependent Care FSA rather than the tax credit on your income tax return. 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 1st 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 health care to dependent care accounts or vice versa.

REIMBURSEMENT PROCESS

You should use your FSA Claim Card wherever it is accepted. If you don't use your debit card, you must submit your claims manually.

To obtain a manual reimbursement from your Medical Expense FSA, you must complete a 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 health care 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 a 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 1.800.720.4460. It is possible to view your Flexible Spending Account balances, check status, claims history and download a claim 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. \$5,000)	\$ _____

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.

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.

Calendar 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.

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.

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.

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.

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.

Maximum Out-of-Pocket - The most money you can expect to pay for covered expenses. Once the maximum out-of-pocket has been met during each calendar year, the health plan pays 100% of certain covered expenses.

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 - 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 year for covered health expenses including copayments and coinsurance but not including any deductibles, prescription drug costs and/or mental health or substance abuse copayments, before the plan pays 100% of covered health expenses for the rest of that year.

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.

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.