YOUR 2015 HEALTHCARE BENEFITS GUIDE

It’s about your health and well-being.

> Full-Time
> Part-Time B, E, F, L
> Part-Time Food Service
> COBRA

what’s inside?
You will find information about your healthcare plans and answers to frequently asked questions.
Benefits Helpline:

Enrollment Help Line
7 a.m. - 8 p.m. ET / Seven days a week
1.305.995.2777

Enrollment Website
www.dadeschools.net

Benefits Inquiry
FBMC Service Center
Mon - Fri, 7 a.m. - 8 p.m. ET
1.855.5MDC.PS4U (1.855.632.7748)

Paper Enrollment Form Assistance for Retirees • COBRA • Part-Time (B,E,F,L):
Office of Risk and Benefits Management
1501 NE 2nd Avenue, Suite 335
Mon - Fri, 8 a.m. - 4:30 p.m. ET
1.305.995.2777, www.dadeschools.net

Healthcare Providers

Over Age 65 (Medicare Eligible) Healthcare Plans
Cigna (Leon Medical Center)
Medicare Advantage
Customer Service
1.866.266.8917 (TTY: 711)
Seven days a week, 8 a.m. - 8 p.m. ET

UnitedHealthcare®
Customer Service (for all plans, including prescriptions)
1.877.776.1466 (TTY 711)
Seven days a week, 8 a.m. - 8 p.m. ET

Enrollment materials for the Medicare Supplement Plan should be returned to:
UnitedHealthcare Enrollment Division
P.O. Box 105331
Atlanta, GA 30348-5337

Under Age 65 (Not Medicare Eligible) Healthcare Plans
Cigna Healthcare
1.800.806.3052
24-hours / Seven days a week
www.Cigna.com

Florida Kidcare
1.888.540.5437
www.floridakidcare.org

Florida Retirement System (FRS)
1.800.377.7687

Medicare
1.800.MEDICARE or 1.800.633.4227,
(TTY: 1.877.486.2048)
24 hours / Seven days a week
www.medicare.gov

Social Security Administration
1.800.772.1213
(TTY: 1.800.325.0178)
www.SSA.gov

Flexible Plan Providers

Dental Plans
Delta Dental
Customer Service at 1.800.693.2589
Mon - Fri, 8 a.m. to 9 p.m. ET
Multilingual representatives are available.
www.deltadentalins.com/mdcps

UnitedHealthcare (UHC) Dental
Dental Member Services
1.800.955.4137
Mon - Fri, 7 a.m. - 10 p.m. CT
www.myuhcdental.com

Vision Plans
Davis Vision
Customer Service: 1.800.999.5431
During Open Enrollment: 1.877.923.2847
Client Code: 4954
www.davisvision.com

UnitedHealthcare Vision
Customer Service
1.800.638.3120
Mon - Fri, 8 a.m. - 11 p.m. ET
Sat, 9 a.m. - 6:30 p.m. ET
Legal Plans
ARAG® Legal Plan
Customer Care
1.800.360.5567
Mon - Fri, 8 a.m. - 8 p.m. ET
www.araglegalcenter.com
Access Code: 10287mds

ARAG SeniorAdvocate® Plan
1.800.360.5567
Mon - Fri, 8 a.m. - 8 p.m. ET
www.araglegalcenter.com
Access Code: 10287mds

MetLaw Legal Plan
1.800.821.6400
Mon - Fri, 8 a.m. - 7 p.m. ET
info.legalplans.com
Access Code: 8900010

MetLaw Senior Plan
1.800.821.6400
Mon - Fri, 8 a.m. - 7 p.m. ET
info.legalplans.com
Access Code: 8890010

The Short-Term & Long-Term Disability Plans
Hartford Life and Accident Insurance Company
Customer Service 1.305.995.4889
To File a Claim 1.800.741.4306
Medical Underwriting 1.800.331.7234
www.thehartfordatwork.com

Identity Theft Plan
ID Watchdog, Inc.
Customer Service 1.866.513.1518
24 hours / Seven days a week
www.idwatchdog.com

Hospital Indemnity Coverage
Life Insurance Co. of North America, a Cigna Company
Customer Service / Claims
1.855.MDC.PS4U (1.855.632.7748)
Mon - Fri, 7 a.m. - 8 p.m. ET

Voluntary Life Insurance and Accidental Death and Dismemberment (AD&D)
MetLife Voluntary Life
Customer Service
1.305.995.7029
Mon - Thurs, 8 a.m. - 4:30 p.m. ET
Claims
1.800.638.6420, option #2
Mon - Thurs, 8 a.m. - 8 p.m. ET
Fri, 8 a.m. - 5 p.m. ET

Flexible Spending Accounts (FSA)
Total Administrative Services Corporation (TASC)
Customer Service
1.800.422.4661
Mon - Fri, 8 a.m. - 5 p.m.
www.tasconline.com

401(k)
VISTA 401(k) Plan
P.O. Box 1878
Tallahassee, Florida 32302-1878
Customer Service
1.866.325.1278
Fax: 1.850.425.8345
IVR: 1.800.213.2310
E-mail: 401k@vista401k.com
www.vista401k.com

Other Important Phone Numbers
For general benefit and enrollment information throughout the year:

Miami-Dade County Public Schools
Office of Risk and Benefits Management
Automated Phone System
1.305.995.7129
1.305.995.7130
Fax: 1.305.995.7190
Mon - Fri, 8 a.m. - 4:30 p.m. ET

Office of Retirement/Leave/Unemployment
1.305.995.7090

Payroll Deduction Control
Automated Phone System
1.305.995.1655
Fax: 1.305.995.1644
Mon - Fri, 8 a.m. - 4:30 p.m. ET

Life Insurance
MetLife Group Life Claims
Customer Service
1.305.995.7029
Mon - Fri, 8 a.m. - 4:30 p.m. ET
Claims
1.800.638.6420, option #2
information throughout the year.
Fax: 1.305.995.7190
Mon - Thurs, 8 a.m. - 8 p.m. ET
Fri, 8 a.m. - 5 p.m. ET
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Healthy Tip:

Get to know your doctor!
Now is a great time to schedule an annual physical or check up with your Primary Care Physician (PCP) for yourself and your dependents.
What's New

If you do not re-enroll during this Open Enrollment period, your healthcare and your dependent(s)' healthcare coverage, along with your disability coverage, will continue. Your flexible benefits will terminate December 31, 2014. To continue your flexible benefits, you will have to re-enroll during this Open Enrollment period. You will need your dependent(s)' Social Security numbers to successfully enroll your dependents.

About Your 2015 Plan Year Open Enrollment

This Open Enrollment is for benefits effective January 1, 2015 through December 31, 2015. M-DCPS benefits eligible, active employees continue to be offered a free healthcare option, access to providers of their choice and to specialists without a referral. The Cigna LocalPlus plan is the free option, and this year both OAP 10 and OAP 20 will have a cost share for employee-only coverage based on the employee benefits base salary. Also, in accordance with the Affordable Care Act (ACA), medical, Rx costs, deductibles and co-insurance will continue to be counted toward your Annual Maximum Out-of-Pocket (MOOP). Employees save more because once the MOOP has been reached, there are no other costs to pay.

Additionally, dependent premiums will continue to be subsidized by the Board and employees covering a domestic partner of the same sex and legally married are able to add their eligible domestic partner on a tax-free basis with a marriage certificate.

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

The School Board of Miami-Dade County, Florida reserves the right to amend or to terminate the plans described in this guide at any time, subject to the specific restrictions, if any, in the collective bargaining agreements. In the event of any such amendment or termination, your coverage may be modified or discontinued and the School Board assumes no obligation to continue the benefits or coverage described in this guide.
2015 Open Enrollment

• Three plans will be offered for calendar year 2015
• The Cigna LocalPlus Plan is comprised of a network of physicians that have demonstrated the best outcomes.
• Effective January 1, 2015 the Cigna LocalPlus Plan will be enhanced to include all Vital MD contracted physicians including obstetricians/gynecologists, primary care physicians, and selected specialists.
• Employees are not required to select a primary care physician and referrals are not needed when seeking services from a specialist.
• Employees represented by the AFSCME Bargaining Unit will be selecting a primary care physician at the time of enrollment.
• All United-Health physicians continue to be in the Cigna LocalPlus network. Primary medical care at UnitedHealth Medical Center at Miami-Jackson Senior High School for all healthcare plans is provided at a $10 co-payment.
• Employees represented by the AFSCME Bargaining Unit are eligible to enroll in the Cigna LocalPlus Plan.
• AFSCME Flex Credit: Employees represented by the AFSCME Bargaining Unit enrolled in the District’s healthcare plan will continue to receive an annual flex credit. The annual flex credit of $230 can be used to offset the cost of flexible benefits or the medical cost-share when enrolling in Cigna OAP 20.

2015 Plan Year Prescription Enhancements for all three Cigna Healthcare Plans

• Opportunity for enrollment in CoachRx, providing direct access to pharmacists, including assistance with adherence, side effects, drug to drug interaction, financial assistance, a free pill box, as well as a co-payment assistance program and slow pay.
• Establishment of automated refill reminder for phone or e-mail.
• All temperature sensitive pharmaceuticals, including insulins which do not require a signature, will be sent overnight with the employee having the opportunity to select an alternative delivery address.
• In the event the mail ordered pharmaceutical delivery is not completely successful, the affected employee may request another delivery and/or an interim dispensing until a successful mail delivery can occur.
• Class II and III narcotics can be either shipped via home delivery or dispensed at a retail pharmacy, depending upon the wishes of the employee with the concurrence of his/her physician.
• Automated refill reminder program will move from opt-in to default during the course of calendar year 2015.
• Ability to utilize Cigna ID card to obtain box store Rx pharmaceuticals at free or low co-payment pricing to obtain information for purposes of case management, gaps in care, disease management and health coaches with eligible maintenance medications which are subject to mandatory mail away to be subject to the maximum three refills at retail.
• Enhanced home delivery communication to District employees with specific telephonic prompt to facilitate delivery problems and problem solving.
• Issuance of reminder letters to employees who have eligible maintenance medications filled at a retail pharmacy that they will need to switch to mail order after three retail refills.
• Educational Sessions at the work locations: November 18th – November 24th
• Open Enrollment Period: November 25th - December 10th
• 2015 Open Enrollment first payroll: January 9, 2015
• Benefits salaries will remain at the present levels, which are benefits salaries determined during calendar year 2011.

2015 Wellness Initiatives

In our continuous effort to increase awareness and wellness engagement, the wellness initiatives deadline has been extended until September 30th, 2015 (applies only to the unions that agree to include this extension in their contracts), in order to provide all employees the opportunity of completing the following four initiatives and being eligible to enroll in any employee-only no cost healthcare option.

Benefits eligible employees enrolled in healthcare plans are required to complete the following:

• Register on www.mycigna.com
• Have an annual physical - preventive visit
• Have biometric screenings (blood work) performed
• Complete the Health Risk Assessment
• This applies only to employees represented by the following unions: DSCMEC, UTD, DSCAA, MEP & CEP. Failure to meet this deadline of September 30, 2015 will not provide the employee the opportunity of enrolling in the free healthcare option (if one offered) in 2016.

Benefits eligible employees must complete the 2015 Wellness Initiatives no later than September 30, 2015 (applies only to the unions that agree to include this extension in their contracts). Failure to meet this deadline will result in the inability to enroll in an offered healthcare option without a cost share (free option) effective January 1, 2016. All collected medical data will be in accordance with the Federal HIPAA Laws protecting the integrity of personal medical data.
Full-Time Employee Benefits Update

- All employees must view their 2015 Benefits Statement via the Internet.
- Employees will now be able to determine the value of their dental and vision plan by answering questions regarding services that they might receive in 2015. A tool has been designed to calculate and display the anticipated cost for each plan allowing you to personalize your selection.

This is a changes only enrollment for healthcare. If you do not make changes during this open enrollment period:
- Your current benefits will continue. Any changes to plan designs and premiums will become effective January 1, 2015 and deducted from the first 2015 Plan Year payroll, on January 9, 2015.
- If you are currently enrolled in Cigna OAP 20 Employee Only you will automatically be charged the employee cost share, a per pay deduction determined by your benefits salary band.
- If you are currently enrolled in Cigna OAP 10 Employee Only your current employee cost share will automatically be adjusted.
- If you are covering dependents, your dependent coverage will continue and plan design changes and premiums will automatically be adjusted.

**NOTE:** If you did not submit your dependent documentation in 2014, you will have to submit it after the 2015 Open Enrollment. If you do not submit your documentation, your dependents will be terminated after being provided the opportunity to submit your documentation.

Additionally, employees covering a domestic partner of the same sex could pay for their dependent premiums on a tax free basis by providing a copy of their marriage certificate.
- Changes made during this enrollment period will be effective January 1, 2015 and the changes will be reflected on the January 9, 2015 paycheck.
- If you are currently opting out of healthcare and do not elect to enroll in healthcare during this enrollment period, your current opt out selection will continue. You will have to submit your proof of other group healthcare plan or state-funded program.

**New Employees:**

A new employee is defined as an employee without active benefits. If you are a new employee hired during this Open Enrollment period, you enroll for both plan years. You will receive an email prompting you to enroll online for your benefits. You must enroll online by the due date. Otherwise, you will be automatically assigned for the remainder of the 2014 plan year in Cigna LocalPlus (employee-only) coverage and the Standard Short-Term Disability Plan.

However, if you do not make a change during the 2015 Open Enrollment period, you will be automatically assigned, effective January 1, 2015, to the Cigna LocalPlus Plan (employee-only).

**Benefits Update**

- The Board provides Cigna LocalPlus at no cost to the employee.
- Employees represented by the AFSCME Bargaining Unit are eligible to enroll in the Cigna LocalPlus Plan.
- Employees represented by the AFSCME bargaining unit are eligible to enroll in the Cigna LocalPlus Plan.
- Cigna OAP 20 & OAP 10 has an employee cost share determined by the employee’s benefits salary band.
- Benefits salaries will remain at the present levels for one additional year which are benefits salaries determined during calendar year 2011.
- The Board will continue to subsidize a portion of your dependent’s healthcare coverage.
- In accordance with the Affordable Care Act (ACA) medical, Rx costs, deductibles and co-insurance are counted toward your Annual Maximum Out-of-Pocket (MOOP). Employees save more because once the MOOP has been reached, the employee will be covered 100 percent and will have no other healthcare costs to pay.
- New-hire employees hired after January 1, 2015 will continue to have their healthcare coverage effective the day of hire and will start paying for the cost share if enrolling in either Cigna OAP 20 or OAP 10 on the first paycheck following the effective date of the healthcare plan.
- All benefits eligible employees are provided with Board-paid Standard Short-Term Disability (STD) coverage.
- The School Board provides a Term Life and Accidental Death and Dismemberment (A&D&D) program with Metropolitan Life Insurance Company for all full-time employees. The coverage amount is either one or two times your annual base salary, rounded up to the next $1,000. Administrators and Confidential Exempt employees receive two times the annual base salary. All other employees receive one times their annual base salary. The minimum benefit for employees represented by AFSCME is $10,000. Additional life insurance may be purchased through payroll deduction to bring maximum benefits to an additional, one times the amount provided by the School Board. You will be eligible to increase your coverage to a maximum of five times the annual base salary after the first year of participation in the optional life program. Evidence of Insurability will be required for any increases in coverage. To find out more about Board-Paid Term Life and Accidental Death and Dismemberment, contact the MetLife representative at 1.305.995.7029.

All employees must view their 2015 benefits statement via the Internet. To make changes to your current benefits and view your benefits statement, log on to www.dadeschools.net.
- Log-in to the Employee Portal
- Enter your login username and password
- Check on the "2015 Open Enrollment" link.
Healthcare Frequently Asked Questions

Get answers to commonly-asked healthcare coverage questions!

>> Important Note:
Attention all Full-Time employees, Part-Time employees, Retirees and COBRA participants!

If you do not re-enroll during this enrollment, your and your dependents' healthcare coverage will continue.

1Q. What is a co-payment?
A. A co-payment is a fixed dollar amount you pay for covered healthcare services. The amount will vary by type of plan and covered service.

2Q. What is a Cigna Care Network (CCN) specialist?
A. A CCN Specialist is a Specialist of a designated network that has been identified by Cigna to have demonstrated the best outcome in management in patient treatment. This network includes both primary care physicians and specialists.

3Q. What specialties are included in this network?
A. There are 22 specialist providers located in South Florida.

4Q. How do I determine if my specialist is on the CCN network?
A. Log-in to www.cigna.com and click on Find a Doctor. You can search by name or specialty. Once you're on the online directory, look for the Special Cigna Designated Symbol.

5Q. What is an annual deductible?
A. An annual deductible is the annual amount you are responsible for medical services provided in a hospital or hospital-affiliated facility. This amount is separate from any co-payments.

6Q. What does the annual maximum out-of-pocket (MOOP) mean?
A. The annual maximum out-of-pocket is the amount you are responsible for before the plan pays 100 percent.

7Q. What does the plan co-insurance mean?
A. The plan co-insurance is the percentage by plan you pay for medical services provided in a hospital or hospital-affiliated facility. Co-insurance does not apply to fixed co-payments.

8Q. What happens if I am hospitalized?
A. Hospital admissions are subject to deductibles and co-insurance.
9Q. What are convenience care centers and what are the co-payments for these centers?
A. Convenience care centers are located in retail stores and pharmacies; they’re often open at night and on weekends. These centers are staffed by board-certified nurse practitioners and physician assistants to treat minor medical concerns that are not life threatening.

10Q. What are urgent care centers and what are the co-payments?
A. Those are centers for medical conditions that are not life-threatening. Urgent Care Centers are staffed with nurses and doctors, and always are open on evenings and weekends. Both in and out-of-networks Urgent Care Centers are covered at 100 percent after paying the set co-payment.

11Q. What's an emergency room and what is my co-payment?
A. Emergency rooms are located in all hospitals and are for immediate treatment of critical injuries or illnesses. Services are covered 100 percent after set co-payment after the plan deductible is met.

12Q. What is a mandatory prescription mail order program?
A. This program is designed for prescription medications taken on a regular basis, including specialty drugs. Employees must request a prescription from their doctor for a 90-day supply with refills. Cigna Home Delivery Pharmacy will deliver a 90-day supply to your home with a co-payment of two times the tier cost, saving you time, money, and inconvenience.

13Q. How are Prescription Drugs Retail (up to 31-day supply) classified?
A.
Tier 1 - Generic Medications
Tier 2 - Preferred Brand Medications (when generic is not available)
Tier 3 - Co-insurance (minimum $ & maximum $) Non-Preferred Brand Medications (These medications have a generic or a Tier 2 alternative within the same drug class.)

14Q. What’s a Narrow Retail Pharmacy Network?
A. This is a network of participating pharmacies where prescriptions can be filled. All other pharmacies are not participating in the plan.

15Q. Which are the pharmacies participating in the Narrow Retail Network?
A. Only Walgreens, Walmart, Publix, Navarro and specifically-identified, independent pharmacies are in the network.

16Q. What pharmacies offer discounts on prescriptions outside of the School Board's healthcare plan?
A. Some retail pharmacies offer very low prices on selected generic drugs, often less than the co-payment on your Cigna Plan. These alternative prescription programs are offered at:
• Walmart
• Target
• Walgreens
• CVS Pharmacy
• Publix

17Q. Can I decline healthcare coverage?
A. Yes, active benefits-eligible employees can decline healthcare coverage and, you will receive a monthly contribution of $100 paid through the payroll system based on your deduction schedule (subject to withholding and FICA).
Additionally, you must be enrolled in a group or state funded healthcare plan to decline healthcare coverage. You will be required to submit proof of this other enrollment. If proof is not submitted, your declination selection will be cancelled and you will automatically be enrolled in Cigna LocalPlus employee-only coverage.

Money Saving Tip:
Take charge of your health! Consult with your doctor about equivalent, generic prescription medications to save money.
Healthcare Frequently Asked Questions

18Q. What’s the coverage for Durable Medical Equipment (DME)?
A. After you have satisfied the annual deductible:
   - OAP 20 Plan will pay 70% in network and 50% non-network.
   - OAP 10 Plan will pay 80% in network and 60% non-network.
   - Cigna LocalPlus will pay 30% in network and 50% non-network.
Once you have met your maximum out of pocket, the coverage will be 100%.

19Q. Is there a cost when enrolling in Cigna LocalPlus?
A. No, the Cigna LocalPlus Plan is no cost for employee-only coverage.
   (applies to active benefits eligible employees).

20Q. Is there a cost when enrolling in Cigna OAP 10 or OAP 20?
A. Yes, both plans will have a cost share for 2015, based on the employee's benefit salary
   (applies to active benefits eligible employees).

21Q. Will M-DCPS continue to subsidize the cost of dependent premiums?
A. Yes, M-DCPS will continue to subsidize dependent premiums between 39-83 percent.

22Q. Will dependent premiums continue to be based on my annual base salary (by salary bands)?
A. Yes, salary bands were negotiated as of January 1, 2010. Dependent healthcare subsidies are based upon
   higher subsidies being in place for the lower paid employees. Additionally, the benefit salary will remain
   at present levels, which are benefits salaries determined during the calendar year 2011.

23Q. Must all eligible employees enroll during this enrollment period for benefits, effective January 1, 2015?
A. No, this is a changes only enrollment and if you do not re-enroll during this open enrollment period,
   your current healthcare coverage will continue. Both plan design changes and premiums will automatically
   be adjusted. Also, if you have selected to decline the School Board’s healthcare coverage, and do not re-enroll,
   your opt-out decision will roll over. However, you must re-submit proof of enrollment in state funded or
   other group healthcare. If proof is not submitted, you will automatically be enrolled in Cigna LocalPlus Plan,
   employee-only coverage.

24Q. What number do I call for additional information on the healthcare plan?
A. Call Cigna Healthcare at 1.800.806.3052, 24-hours/7 days a week.

25Q. What number do I call for additional information on my enrollment and all other benefits?
A. Call the FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday through Friday, 7 a.m. – 8 p.m. ET.

Money Saving Tip:
Make sure your doctor is In-Network to receive discounted healthcare services!
Check www.cigna.com and www.mycigna.com to find the CCN provider network.
NEW PLAN ENHANCEMENT:

MAXIMUM OUT-OF-POCKET ADJUSTMENT:
Medical and prescription (Rx) co-payments, plus deductibles and co-insurance, are counted toward a member’s annual Out-of-Pocket (OOP) Maximum – if employees choose an in-network healthcare provider.

Members save more because of the adjustment and once their maximum out-of-pocket, in-network expenses are reached, there are no other costs to pay.

SAVE MORE WITH A MEDICAL EXPENSE FSA!
With this new plan enhancement, you have the opportunity to save your pre-tax dollars by enrolling in a Medical Expense FSA for reimbursement of eligible medical expenses, such as co-payments, deductibles, Rx co-payments and co-insurance.

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**2015 Affordable Care Act Savings**

**Using In-Network Providers lowers your Out-of-Pocket Maximum**

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**Employee OOP Expenses**
- Medical co-payments
- Rx co-payments
- Deductibles
- Co-insurance

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**Out-of-Pocket Maximum**

**FAMILY**

maximum annual out-of-pocket

**INDIVIDUAL**

maximum annual out-of-pocket

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**Example**

Co-payments count toward your annual out-of-pocket maximum.

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<th>DESCRIPTION</th>
<th>VISITS / PRESCRIPTIONS</th>
<th>OUT-OF-POCKET MEMBER COST</th>
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</tr>
<tr>
<td>Specialty Care Physician Office visit co-payments*</td>
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</tr>
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<td>Pharmacy co-payments*</td>
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</tr>
<tr>
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<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**SUB TOTAL** $6,250

**TOTAL MEMBER OUT-OF-POCKET COSTS** $4,000 capped with no additional costs

**SAVING WITH THE NEW PLAN DESIGN** $2,250

* Benefits that now count towards annual maximum out-of-pocket (MOOP) maximum.
Part-Time Healthcare FAQs

Open Enrollment for 2015 Employee Benefits will be held from November 25, 2014 through December 10, 2014. If you do not enroll during this Open Enrollment period, your current healthcare coverage will continue. We will automatically adjust the benefits changes and premiums; you will receive a bill in January reflecting the 2015 rates. Additionally, your current flexible benefits will terminate December 31, 2014; you must re-enroll to have benefits in plan year 2015.

Healthcare Benefits
You may select from two Cigna healthcare plans. Dependents must be covered under the same plan as the employee. The healthcare plans are:
- Cigna Open Access Plus (OAP) 20
- Cigna Open Access Plus (OAP) 10
- Cigna LocalPlus Plan

To enroll in a Cigna plan, effective January 1, 2015, you must request an enrollment form. If you are adding dependents, you must include your dependent’s Social Security number on the form and submit dependent eligibility documentation (i.e., marriage certificate for a spouse and birth certificate for a child, etc.). Mail your completed form, with your first month premium, payable to The School Board of Miami-Dade County, Florida to:

Miami-Dade County Public Schools
P.O. Box 12241
Miami, Florida 33101

To obtain a healthcare benefits enrollment form, contact Miami-Dade County Public Schools:
- 1.305.995.2883, Monday - Friday, 8 a.m. - 4:30 p.m. ET

NOTE: There is no Board contribution toward the employee’s or dependent(s) coverage. Part-Time employees are responsible for the full, monthly cost of the Board-approved healthcare plans.
Part-Time Healthcare FAQs

1Q. Do I have to enroll during the 2015 Open Enrollment period?
A. No. This is a changes only enrollment. You only need to submit an enrollment form if making changes to your current benefits.

2Q. Will I receive a new set of coupons for 2015?
A. Yes. You will be receiving a new set of coupons with your selections or if continuing with your current healthcare plan, a new set of coupons will be mailed reflecting your new premium.

3Q. Can I add my dependent(s) during this enrollment period?
A. Yes, you can add your eligible dependents during this enrollment period and you will have to submit the dependent documentation for each dependent.

4Q. Can I cancel my dependents' coverage during this enrollment period?
A. Yes. You can terminate your dependent coverage, but you will not be eligible to re-enroll until the next Open Enrollment provided you have maintained your enrollment in a School Board sponsored healthcare plan.

5Q. Can I choose one healthcare plan for myself and a different one for my eligible dependents?
A. No. You and your dependents must be enrolled in the same healthcare plan if all being covered are not Medicare eligible.

6Q. Do I have to submit dependent documentation for my covered dependents?
A. Yes. Dependent documentation must be submitted for all covered dependents if not previously submitted. If documentation is not submitted prior to the commencement of the 2015 Plan Year, your covered dependents' coverage may be terminated.

7Q. Are the healthcare plans I am being offered different from those offered to the active benefits-eligible employees?
A. No. You are offered the same benefits being offered to the active benefits-eligible employees. Please refer to the front pages of this book for the description of the healthcare plans being offered.

8Q. Must I complete the 2015 Wellness Requirements?
A. The District encourages its employees to establish a relationship with a physician and to have an annual physical.

9Q. What happens to my benefits if my employment is terminated?
A. If you are no longer employed by the School Board, and are not eligible to purchase benefits, you will be provided the opportunity to continue your benefits. In accordance with the Federal COBRA Law, you will be provided the ability to continue with your medical, dental and/or vision plan if purchasing them as a part-time employee. Premiums must be paid up-to-date to be eligible for COBRA continuation.
Part-Time Food Service Healthcare FAQs

1Q. Do I have to enroll during the 2015 Open Enrollment Period?
A. No. This is a changes only enrollment, you only need to submit an enrollment form if making changes to your current benefit. However, you are now eligible to enroll in the Cigna LocalPlus Plan.

2Q. Can I add my dependents during this enrollment period?
A. Yes, you can add your eligible dependents during this enrollment period and you will have to submit the dependent documentation for each dependent.

3Q. Can I cancel my dependents during this enrollment period?
A. Yes. You can terminate your dependent coverage, but you will not be eligible to re-enroll until the next open enrollment provided you have maintained your enrollment in a School Board sponsored healthcare plan.

4Q. Can I choose one healthcare plan for myself and a different one for my eligible dependents?
A. No. You and your dependents must be enrolled in the same healthcare plan if all being covered are not Medicare eligible.

5Q. Do I have to submit dependent documentation for my covered dependents?
A. Yes. Dependent documentation must be submitted for all cover dependents if not previously submitted. If documentation is not submitted prior to the commencement of the 2015 Plan Year, your covered dependents will be terminated.

6Q. Are the healthcare plans I am being offered different from those offered to the active benefits eligible employees?
A. No. You are offered the same benefits being offered to the active benefits eligible employees. Please refer to the front pages of this book for the description of the healthcare plans being offered.

7Q. Will my healthcare benefits continue if I am on a Board-approved leave of absence?
A. If you are out on a Board-approved leave that's eligible for benefits, your healthcare coverage will continue. If you are out on a leave of absence that does not provide you with healthcare benefits, you will be given the opportunity of continuing your benefits at your cost.
For additional information regarding your current leave status or you want to apply for a leave contact the Leave Office at 305.995.7090.

8Q. What happens to my healthcare benefit if my employment terminates?
A. If you are no longer employed by the School Board, and not eligible to purchase benefit, you will be provide the opportunity of continuing your benefits. In accordance with the COBRA Federal Law, you will be provided the ability to continue with your medical, dental and/or vision plan if purchasing them as a part time employee. Premiums must be paid up to date to be eligible for COBRA continuation.

9Q. Must I complete the 2015 Wellness Requirements?
A. The District encourages its employees to establish a relationship with a physician and to have an annual physical.
1Q. Do I have to enroll during the 2015 Open Enrollment period?
   A. No. This is a changes only enrollment, you only need to submit an enrollment form if making changes to your current benefits.

2Q. Will I receive a new set of coupons for 2015?
   A. Yes. You will be receiving a new set of coupons with your selections, or if continuing with your current healthcare plan, a new set of coupons will be mailed reflecting your new premium.

3Q. Can I add my dependents during this enrollment period?
   A. Yes, you can add your eligible dependents during this enrollment period and you will have to submit the dependent documentation for each dependent.

4Q. Can I cancel my dependents' coverage during this enrollment period?
   A. Yes. You can terminate your dependent coverage, but you will not be eligible to re-enroll until the next open enrollment provided you have maintained your enrollment in a School Board sponsored healthcare plan.

5Q. Can I choose one healthcare plan for myself and a different one for my eligible dependents?
   A. No. You and your dependents must be enrolled in the same healthcare plan if all being covered are not Medicare eligible.

6Q. Do I have to submit dependent documentation for my covered dependents?
   A. Yes. Dependent documentation must be submitted for all covered dependents if not previously submitted. If documentation is not submitted prior to the commencement of the 2015 Plan Year, your covered dependents' coverage will be terminated.

7Q. Are the healthcare plans I am being offered different from those offered to the active benefits-eligible employees?
   A. No. You are offered the same benefits being offered to the active benefits-eligible employees. Please refer to the front pages of this book for the description of the healthcare plans being offered.

8Q. Must I complete the 2015 Wellness Requirements?
   A. The District encourages its employees to establish a relationship with a physician and to have an annual physical.
Important information about your healthcare choices:

- Your plan provides you coverage when you’re sick or injured by focusing on helping you take care of yourself so you can stay your healthiest.
- Covers emergency and urgent care 24 hours a day.
- Gives you options for accessing quality healthcare.
- Provides you the option of using either in-network or out-of-network providers.
- All three plans offer you a Cigna Care Network (CCN), a network of physicians identified by Cigna Healthcare that meets or exceeds specific quality and cost efficiency standards.
- No referrals needed: all three plans provide you direct access to specialists without a referral.
- Participating providers: Cigna offers personalized search capability to easily find the right physician and facility for you.

For the OAP 10 & OAP 20 Plans: log in to your www.mycigna.com account and click on the Find a Doctor or Service link.

For the Cigna LocalPlus Plan: log onto www.cigna.com and click on the Offered Cigna through work link. Participating providers of this plan are identified by LocalPlus appearing underneath the Plans Accepted column.

- Also, in accordance with the Affordable Care Act (ACA) medical, prescription costs, deductibles and co-insurance are counted toward your annual Maximum Out-of-Pocket (MOOP) to help employees save more because once the MOOP has been reached, there are no other costs to pay.
How does the Cigna Open Access (OAP) 10 Plan work?
• Cigna OAP 10 continues to have a per pay employee cost share determined by the employee’s 2011 Benefits Base Salary (Cigna OAP 20 is no longer a free option for active benefits-eligible employees).
• In-Network Individual Deductible - $500
• In-Network Family Deductible - $1,000
• In-Network Individual Maximum Out-of-Pocket - $3,750
• In-Network Family Maximum Out-of-Pocket - $7,500
• In-Network co-insurance - 20%
• Employee is not required to select a Primary Care Physician

What are your benefits under the Cigna OAP 10?
• In-Network Individual Deductible - $500
• In-Network Family Deductible - $1,000
• In-Network Individual Maximum Out-of-Pocket - $3,750
• In-Network Family Maximum Out-of-Pocket - $7,500
• In-Network co-insurance - 20%
• Employee is not required to select a Primary Care Physician
• Employee has direct access to a specialist without a referral
• Primary Care Physicians Office Visits - $30 co-payment
• Cigna Care Specialist Network (CCN)- specialists identified by Cigna to have demonstrated the best in management of patient treatment
• CCN Specialist Physician’s Office Visits - $50
• Non CCN Specialist Physician’s Office Visits - $70
• Convenience Care Center - $15
• Urgent Care - $70
• Emergency Room - $350/ Jackson Memorial Health Systems $175
• Outpatient diagnostic tests/surgeries/procedures at a non-hospital affiliated facility will remain at $100 per test/procedure.
• Durable Medical Equipment (DME) - deductible and co-insurance will continue to apply.
• Generic Medication - $20
• Brand Name Medication - $50
• Non-Preferred Brand Name Medication - employee pays 50% ($105 Minimum / $160 Maximum)
• Mandatory Prescriptions Mail Order Program - delivers prescribed medications to the employee’s home.
  > Generic Seven Drug Classes - $20 - for identified maintenance drugs will be covered with one month co-payment for a 90-day supply through the mail-away program for the following related conditions:
    - Asthma
    - Blood Pressure
    - Blood Thinner
    - Cholesterol
    - Diabetes
    - Osteoporosis
    - Prenatal Vitamins
  > A 90-day supply with a co-payment of two times the tier cost, saving time and money:
    - Generic Medication - $40
    - Brand Name Medication - $100
    - Non-Preferred Brand Name Medication - employee pays 50% ($210 Minimum / $320 Maximum)

Click to play the Tips for Managing Your Blood Pressure Video:
How does the Cigna Open Access (OAP) 20 Plan work?

• This year, Cigna OAP 20 has a per pay employee cost share, determined by the employee's 2011 Benefits Base Salary. Cigna OAP 20 is no longer a free option for active benefit-eligible employees.

• Provides you the flexibility of electing, at the time of service, in or out-of-network provider.

• When using a participating in-network physician, your co-payments are a fixed dollar amount.

• When using participating in-network physician affiliated with a hospital, a deductible, co-insurance and maximum out-of-pocket applies.

• When using a non-participating, out-of-network provider, you are responsible for the deductible, co-insurance and maximum out-of-pocket limit.

• Co-insurance is 30 percent shared. You pay a calculated percentage of the allowable amount.

• Your out-of-pocket cost for:
  » Co-payments
  » Deductible
  » Co-insurance
  » Prescriptions

The total cost annually to you is now counted toward your Maximum, Out-Of-Pocket (MOOP). Once you have satisfied (paid) the MOOP, there are no other costs to you when using the plan.

What are your benefits under the Cigna OAP 20?

• Cigna OAP 20 continues to have a per pay employee cost share determined by the employee's 2011 Benefits Base Salary.

• In-Network Individual Deductible - $750

• In-Network Family Deductible - $1,500

• In-Network Individual Maximum Out-of-Pocket - $4,000

• In-Network Family Maximum Out-of-Pocket - $8,000

• In-Network co-insurance - 30%

• Employee is not required to select a Primary Care Physician

• Employee has direct access to a specialist without a referral

• Primary Care Physician Office Visits - $30 co-payment

• Cigna Care Specialist Network - specialist identified by Cigna to have demonstrated the best in management of patient treatment

• CCN Specialist Physician's Office Visits - $50

• Non CCN Specialist Physician's Office Visit - $70

• Convenience Care Center - $15

• Urgent Care - $70

• Emergency Room - $350 / Jackson Memorial Health Systems $175

• Outpatient diagnostic tests/surgeries/procedures at a non-hospital affiliated facility will remain at $100 per test/procedure.

• Durable Medical Equipment (DME) - deductible and co-insurance will continue to apply.

• Generic Seven Drug Classes - $15

• Generic Medication - $15

• Brand Name Medication - $45

• Non-Preferred Brand Name Medication- employee pays 50% ($105 Minimum / $160 Maximum)

• Mandatory Prescriptions Mail Order Program - delivers prescribed medications to the employee's home.

  » Generic Seven Drug Classes - $15 - for identified maintenance drugs will be covered with one month co-payment for a 90-day supply through the mail-away program for the following related conditions:
    - Asthma
    - Blood Pressure
    - Blood Thinner
    - Cholesterol
    - Diabetes
    - Osteoporosis
    - Prenatal Vitamins

  » A 90-day supply with a co-payment of two times the tier cost, saving time and money:
    - Generic Medication - $30
    - Brand Name Medication - $90
    - Non-Preferred Brand Name Medication - employee pays 50% ($210 Minimum / $320 Maximum)

Money Saving Tip:

Save money by using the Emergency Room only for urgent events that cannot wait until your doctor's normal hours of operation.
What are your benefits under the Cigna LocalPlus Plan?

Free Option Plan, no cost for employee-only coverage.

- Plan offers a select network of outcome-based physicians in selected areas.
- In-Network Individual Deductible - $750
- In-Network Family Deductible - $1,500
- In-Network Individual Maximum Out-of-Pocket - $4,000
- In-Network Family Maximum Out-of-Pocket - $8,000
- In-Network co-insurance - 30%
- Employee is not required to select a Primary Care Physician
- Employee has direct access to a specialist without a referral
- Employee may access non-participating providers at a higher out-of-pocket expense
- Primary Care Physicians Office Visits - $20 co-payment
- Specialist Physician’s Office Visits - $50
- Convenience Care Center - $10
- Urgent Care - $70
- Emergency Room - $300 / Jackson Memorial Health Systems - $150
- Outpatient diagnostic tests/surgeries/procedures at a non-hospital affiliated facility will remain at $100 per test/procedure.
- Durable Medical Equipment (DME) - deductible and co-insurance will continue to apply.
- Generic Medication - $15
- Brand Name Medication - $40
- Non-Preferred Brand Name Medication - employee pays 50% ($100 Minimum / $150 Maximum)
- Mandatory Prescriptions Mail Order Program - delivers prescribed medications to the employee’s home.

> Generic Seven Drug Classes - $15 - for identified maintenance drugs will be covered with one month co-payment for a 90-day supply through the mail-away program for the following related conditions:
  - Asthma
  - Blood Pressure
  - Blood Thinner
  - Cholesterol
  - Diabetes
  - Osteoporosis
  - Prenatal Vitamins

> A 90-day supply with a co-payment of two times the tier cost, saving time and money:
  - Generic Medication - $30
  - Brand Name Medication - $80
  - Non-Preferred Brand Name Medication - employee pays 50% ($200 Minimum / $300 Maximum)

How does the Cigna LocalPlus Plan Work?

- The plan offers a select network area of local Cigna-care designated physicians.
- The Plan offers both an in and out-of-network benefit.
- Additionally, when outside the LocalPlus network area, use a physician that participated in the Cigna Open Access Plus (OAP) Plan and still receive in-network coverage.
- No referrals
- No need to choose a primary care physician
- Cigna LocalPlus Network:
  - South Florida (Miami-Dade, Broward, Monroe, Palm Beach and St. Lucie counties)
  - Austin, Texas
  - Bay Area California (Alameda, Contra Costa, San Francisco, San Mateo and Santa Clara counties)
  - Chicago, Illinois
  - Dallas/Ft. Worth, Texas
  - Orlando, Florida
  - Phoenix, Arizona
  - Southern California (Los Angelos, Orange, Riverside, San Bernardino and San Diego counties)
  - Tampa, Florida
  - Tennessee (Statewide)

Money Saving Tip:

Great money-saving news! Now your co-payments and deductibles count toward your annual out-of-pocket maximum!
Finding a Cigna LocalPlus Plan Doctor?

How can I find out if my doctor is in the Cigna Local Plus Plan?

1. Enter www.cigna.com in your browser
2. Click on “Find a Doctor”
3. Click on arrow next to “Select Search Type”
   • Search for a doctor by Specialty, Name or Place
   • Complete the next two fields and click on “Search”
4. If your doctor is in the Cigna Local Plus Network, Local Plus will show under accepted plans
Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 17 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

**Allowed Amount**
Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

**Appeal**
A request for your health insurer or **plan** to review a decision or a **grievance** again.

**Balance Billing**
When a **provider** bills you for the difference between the provider’s charge and the **allowed amount**. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may **not** balance bill you for covered services.

**Co-insurance**
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan’s** allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

**Complications of Pregnancy**
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren’t complications of pregnancy.

**Co-payment**
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

**Deductible**
The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

**Durable Medical Equipment (DME)**
Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

**Emergency Medical Condition**
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

**Emergency Medical Transportation**
Ambulance services for an **emergency medical condition**.

**Emergency Room Care**
**Emergency services** you get in an emergency room.

**Emergency Services**
Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.
Glossary of Health Coverage and Medical Terms

Excluded Services
Health care services that your health insurance or plan doesn’t pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn’t require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
Glossary of Health Coverage and Medical Terms

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
Glossary of Health Coverage and Medical Terms

How You and Your Insurer Share Costs - Example

Jane’s Plan Deductible: $1,500  Co-insurance: 20%  Out-of-Pocket Limit: $5,000

January 1st
Beginning of Coverage Period

Jane pays 100%
Her plan pays 0%

December 31st
End of Coverage Period

Jane hasn’t reached her $1,500 deductible yet
Her plan doesn’t pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, co-insurance begins
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $200
Jane pays: $0
Her plan pays: $200
Understanding the Importance of Preventive Care Services

Preventive health coverage is one of the most important benefits of your health plan. Getting the right preventive services at the right time can help you stay healthy by preventing diseases or by detecting a health problem at a stage that may be easier to treat.

What is preventive care?

Preventive care services are those provided when you don’t have any symptoms of a disease or medical condition and are not already diagnosed with the condition for which the preventive service would be provided.

Most importantly, preventive care helps you to prevent some illnesses, such as the flu, by getting a vaccine against the disease. It also helps to detect illness that is present, but where there aren’t any symptoms.

Even if you’re in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. Through preventive exams and routine health screenings, your doctor can detect early warning signs of more serious problems. Your plan covers preventive care services. The Patient Protection and Affordable Care Act requires that preventive care services be covered with no patient cost-sharing (deductible, coinsurance or co-payment).

Non-preventive or diagnostic services/supplies that are provided at the time of a preventive care office visit will not be free of charge, you may be required to pay a co-payment, or deductible and coinsurance amount for covered services or supplies that are not preventive.

Additionally, this year benefits-eligible employees are required to do the following by September 30, 2015:

- You must complete your online registration at www.mycigna.com
- Have an annual physical (preventive) at a physician of your choice
- Have biometric screenings (blood work) in order to complete the Health Risk Assessment (HRA)
- You must complete the HRA

Failure to meet these requirements by the deadline of September 30, 2015, will result in the inability to enroll in an offered healthcare option without a cost share (free option) effective January 1, 2016.

NOTE: This is pending Union ratification and approval.

How to make sure your physician is properly coding a preventive care office visit:

Discuss the following with your physician at the time of the visit before you leave the physician’s office:

1. Confirm that correct coding is used: this is the key to accurately process this claim as preventive and free of charge to you.
2. Confirm that preventive care services are being submitted with an ICD-9 code that represents preventive services and not treatment of illness or injury.
3. Confirm that the ICD-9 code is placed as the first diagnosis in the claim.
4. Confirm that the CPT code is designated as “Preventive Medicine Evaluation and Management Services” to differentiate preventive services from a problem-oriented evaluation.

Remember your physician is there to answer all your questions regarding your health. Establish a relationship with your physician, and schedule an appointment today.

Healthcare Enhancement:

Effective January 1, 2015, colonoscopies will be covered 100%. This applies to both diagnostic and preventive, at hospital and stand-alone, non-hospital facilities.

Preventive Healthcare Plan Requirements:

Benefits-eligible employees are now required to do the following:

- You must complete your online registration at www.mycigna.com
- Have an annual physical (preventive) at a physician of your choice
- Have a biometric screening (blood work) in order to complete the Health Risk Assessment (HRA)
- You must complete the HRA

NOTE: This request does not apply to employees represented by the AFSCME bargaining unit.
Prescription Enhancements

2015 Plan Year Prescription Enhancements for All Three Cigna Healthcare Plans

- Seven generic drug classes at a monthly co-payment for a 90-day supply
- Colonoscopies (Preventive and Diagnostics) will be covered 100% (some services may need to be resubmitted due to non-auto adjudication).
- Opportunity for enrollment in CoachRx, providing direct access to Pharmacists, including assistance with adherence, side effects, drug to drug interaction, financial assistance, a free pill box, as well as financial assistance related to co-payment assistance program utilization and slow pay.
- Establishment of automated refill reminder for phone or e-mail.
- All temperature sensitive pharmaceuticals, including insulins which do not require a signature, will be sent overnight with the employee having the opportunity to select an alternative delivery address.
- In the event the mail ordered pharmaceutical delivery is not completely successful, the affected employee may request another delivery and/or an interim dispensing until a successful mail delivery can occur.
- Class II and III narcotics can be either shipped via home delivery or dispensed at a retail pharmacy, depending upon the wishes of the employee with the concurrence of their physician.
- Automated refill reminder program will move from opt-in to default during the course of calendar year 2015.
- Ability to utilize Cigna ID card to obtain Box Store Rx pharmaceuticals at free or low co-payment price points to obtain information for purposes of case management, gaps in care, disease management and health coaches with eligible maintenance medications which are subject to mandatory mail away to be subject to the maximum three (3) fills at retail.
- Enhanced home delivery communication to District employees with specific telephonic prompt to facilitate delivery problems and problem solving.
- Issuance of reminder letters to employees who have eligible maintenance medications filled at a retail pharmacy that they will need to switch to mail away after three retail fills.
Miami-Dade County Public Schools: Open Access Plus

Summary of Benefits and Coverage: This Plan Covers & What it Costs

Open Access Plus Co-payment Plan (OAP10) Coverage Period: 01/01/2015 - 12/31/2015
Coverage for: Individual/Individual + Family | Plan Type: OAP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myCigna.com or by calling 1-800-806-3052

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For in-network providers $500 person / $1,000 family</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For in-network providers $3,750 person / $7,500 family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for <strong>specific</strong> covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of participating providers, see <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-806-3052</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term <strong>in-network</strong>, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don't need a referral to see a specialist.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-806-3052 or visit us at www.myCigna.com.
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-806-3052 to request a copy.
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 co-pay/visit</td>
<td>40% co-insurance</td>
<td>In-network convenience care clinic visit - $15 co-pay/visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>CCN Specialist: $50 co-pay/visit</td>
<td>40% co-insurance</td>
<td>Contact your employer for Cigna Care Network specialties information</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$70 co-pay/visit for chiropractor</td>
<td>40% co-insurance</td>
<td>Coverage for Chiropractic services is limited to 30 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% co-insurance</td>
<td>Out-of-network deductible does not apply to preventive care and immunizations for children through age 15</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Non-Hospital Based: $100 co-pay/x-ray</td>
<td>40% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 co-pay per type of scan/day at Non-Hospital Based</td>
<td>40% co-insurance</td>
<td></td>
</tr>
</tbody>
</table>
## Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost if you use an In-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$20 co-pay/prescription (retail), $40</td>
<td>50% co-insurance</td>
</tr>
<tr>
<td></td>
<td>co-pay/prescription (home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive Generic- (preventive medication listing): $20 co-</td>
<td>Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>pay/prescription (home delivery)</td>
<td></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$50 co-pay/prescription (retail), $100</td>
<td>50% co-insurance</td>
</tr>
<tr>
<td></td>
<td>co-pay/prescription (home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% co-insurance/prescription with $105 minimum/ $160 maximum (retail), 50% co-</td>
<td>Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>insurance/prescription with $210 minimum/ $320 maximum (home delivery)</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% co-insurance/prescription with $105 minimum/ $160 maximum (retail), 50% co-</td>
<td>Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>insurance/prescription with $210 minimum/ $320 maximum (home delivery)</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% co-insurance/Hospital Based or Affiliated</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>$100 co-pay/Non Hospital Based or Affiliated</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room services</td>
<td>$350 co-pay/visit/$175 co-pay/visit at JMH facilities (Memorial, North &amp; South)</td>
<td>Per visit co-pay is waived if admitted</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>$50 co-pay</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>---------none-----------</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$70 co-pay/visit</td>
<td>$70 co-pay/visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>---------none-----------</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% co-insurance</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% penalty for no precertification.</td>
</tr>
</tbody>
</table>

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<table>
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<th>Common Medical Event</th>
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<th>Your Cost if you use an In-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 co-pay/office visit and No Charge/other outpatient services</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 co-pay/office visit and No Charge/other outpatient services</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No Charge</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$50 co-pay/visit for Physical, Speech, and Occupational Therapy</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>$70 co-pay/visit for Pulmonary and Cardiac Rehabilitation</td>
<td>40% co-insurance</td>
<td>50% penalty for failure to precertify. Coverage for Rehabilitation, including Cardiac rehab, services is limited to 40 days annual max per therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>50% penalty for no precertification.</td>
</tr>
</tbody>
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## Open Access Plus Co-payment Plan (OAP10)

### Excluded Services & Other Covered Services

**Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)**
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Routine eye care (Adult)
- Weight loss programs

**Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)**
- Chiropractic care
- Infertility treatment

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Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-806-3052. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-806-3052. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dineke’go shika afohwol ninisingo, kwiiijgo holne’ 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
Coverage Examples
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Amount owed to providers: $7,540</td>
</tr>
<tr>
<td>• Plan pays: $5,670</td>
</tr>
<tr>
<td>• Patient pays: $1,870</td>
</tr>
<tr>
<td><strong>Sample care costs:</strong></td>
</tr>
<tr>
<td>Hospital charges (mother) $2,700</td>
</tr>
<tr>
<td>Routine Obstetric Care $2,100</td>
</tr>
<tr>
<td>Hospital charges (baby) $900</td>
</tr>
<tr>
<td>Anesthesia $900</td>
</tr>
<tr>
<td>Laboratory tests $500</td>
</tr>
<tr>
<td>Prescriptions $200</td>
</tr>
<tr>
<td>Radiology $200</td>
</tr>
<tr>
<td>Vaccines, other preventive $40</td>
</tr>
<tr>
<td><strong>Total</strong> $7,540</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
</tr>
<tr>
<td>Deductible $500</td>
</tr>
<tr>
<td>Co-pays $130</td>
</tr>
<tr>
<td>Co-insurance $1,210</td>
</tr>
<tr>
<td>Limits or exclusions $30</td>
</tr>
<tr>
<td><strong>Total</strong> $1,870</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Amount owed to providers: $5,400</td>
</tr>
<tr>
<td>• Plan pays: $3,720</td>
</tr>
<tr>
<td>• Patient pays: $1,680</td>
</tr>
<tr>
<td><strong>Sample care costs:</strong></td>
</tr>
<tr>
<td>Prescriptions $2,900</td>
</tr>
<tr>
<td>Medical equipment and supplies $1,300</td>
</tr>
<tr>
<td>Office visits &amp; procedures $700</td>
</tr>
<tr>
<td>Education $300</td>
</tr>
<tr>
<td>Laboratory tests $100</td>
</tr>
<tr>
<td>Vaccines, other preventive $100</td>
</tr>
<tr>
<td><strong>Total</strong> $5,400</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
</tr>
<tr>
<td>Deductible $0</td>
</tr>
<tr>
<td>Co-pays $1,400</td>
</tr>
<tr>
<td>Co-insurance $0</td>
</tr>
<tr>
<td>Limits or exclusions $280</td>
</tr>
<tr>
<td><strong>Total</strong> $1,680</td>
</tr>
</tbody>
</table>

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

че No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

че No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

че Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

че Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 122516  BenefitVersion: 3  Plan Name: OAP 10
### Miami-Dade County Public Schools: Open Access Plus

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2015 - 12/31/2015

**Coverage for:** Individual/Individual + Family  |  **Plan Type:** OAP

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**Open Access Plus Co-payment Plan (OAP20)**

This information page is for all groups.

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<td><strong>What is the overall deductible?</strong></td>
<td>For in-network providers $750 person / $1,500 family For out-of-network providers $1,500 person / $3,000 family Does not apply to in-network preventive care, in-network office visits, emergency room visits, urgent care facility visits, prescription drugs Co-payments don't count toward the deductible.</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. For in-network providers $4,000 person / $8,000 family / For out-of-network providers $8,000 person / $16,000 family</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
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<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
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<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
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<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. For a list of participating providers, see <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-806-3052</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No. You don't need a referral to see a specialist.</td>
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<td><strong>Are there services this plan doesn't cover?</strong></td>
<td>Yes.</td>
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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the *allowed amount* of the service. For example, if the health plan's *allowed amount* for an overnight hospital stay is $1,000, your *co-insurance* payment of 20% would be $200. This may change if you haven't met your *deductible*.
- The amount the plan pays for covered services is based on the *allowed amount*. If an out-of-network provider charges more than the *allowed amount*, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the *allowed amount* is $1,000, you may have to pay the $500 difference. (This is called *balance billing*.)
- This plan may encourage you to use in-network providers by charging you lower *deductibles*, *co-payments* and *co-insurance* amounts.

### Common Medical Event

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<th>Out-of-Network Provider</th>
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</tr>
<tr>
<td>Specialist visit</td>
<td>CCN Specialist: $50 co-pay/visit</td>
<td>50% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Non-CCN Specialist: $70 co-pay/visit</td>
<td></td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$70 co-pay/visit for chiropractor</td>
<td>50% co-insurance</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% co-insurance</td>
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<td><strong>If you have a test</strong></td>
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<td>Diagnostic test (x-ray, blood work)</td>
<td>Non-Hospital Based: $100 co-pay/x-ray</td>
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<td></td>
<td>Hospital Based or Affiliated: 30% co-insurance/x-ray</td>
<td></td>
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<tr>
<td></td>
<td>No Charge/blood work</td>
<td></td>
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<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 co-pay per type of scan/day at Non-Hospital Based</td>
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<td></td>
<td>30% co-insurance/Hospital Based or Affiliated</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td>Services You May Need</td>
<td>Your Cost if you use an In-Network Provider</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$15 co-pay/prescription (retail), $30 co-pay/prescription (home delivery) Preventive Generic (preventive medication listing): $15 co-pay/prescription (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$45 co-pay/prescription (retail), $90 co-pay/prescription (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% co-insurance/prescription with $105 minimum/ $160 maximum (retail), 50% co-insurance/prescription with $210 minimum/ $320 maximum (home delivery)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% co-insurance/Hospital Based or Affiliated $100 co-pay Non-Hospital Based or Affiliated</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$350 co-pay/visit/$175 co-pay/visit at JMH Facilities (Memorial, North &amp; South)</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$70 co-pay/visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% co-insurance</td>
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<td></td>
<td>Physician/surgeon fees</td>
<td>30% co-insurance</td>
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<th>Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 co-pay/office visit and No Charge/other outpatient services</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 co-pay/office visit and No Charge/other outpatient services</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No Charge</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$50 co-pay/visit Physical, Speech, and Occupational Therapy</td>
<td>50% co-insurance</td>
<td>50% penalty for failure to precertify.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$70 co-pay/visit Pulmonary and Cardiac Rehabilitation</td>
<td>50% co-insurance</td>
<td>Coverage for Rehabilitation, including Cardiac rehab, services is limited to 40 days annual max per therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>50% penalty for no precertification.</td>
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Excluded Services & Other Covered Services

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<tr>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)</th>
</tr>
</thead>
</table>
| ● Acupuncture  
| ● Bariatric surgery  
| ● Cosmetic surgery  
| ● Dental care (Adult)  
| ● Dental care (Children)  
| ● Eye care (Children)  
| ● Habilitation services  
| ● Hearing aids  
| ● Long-term care  
| ● Non-emergency care when traveling outside the U.S.  
| ● Private-duty nursing  
| ● Routine eye care (Adult)  
| ● Routine foot care  
| ● Weight loss programs |

<table>
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<tr>
<th>Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
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</table>
| ● Chiropractic care  
| ● Infertility treatment |
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-806-3052. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-806-3052. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek‘ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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Coverage Examples
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

### Having a baby (normal delivery)
- Amount owed to providers: $7,540
- Plan pays: $4,920
- Patient pays: $2,620

#### Sample care costs:
- Hospital charges (mother): $2,700
- Routine Obstetric Care: $2,100
- Hospital charges (baby): $900
- Anesthesia: $900
- Laboratory tests: $500
- Prescriptions: $200
- Radiology: $200
- Vaccines, other preventive: $40

#### Total: $7,540

#### Patient pays:
- Deductible: $750
- Co-pays: $110
- Co-insurance: $1,730
- Limits or exclusions: $30

#### Total: $2,620

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)
- Amount owed to providers: $5,400
- Plan pays: $3,960
- Patient pays: $1,440

#### Sample care costs:
- Prescriptions: $2,900
- Medical equipment and supplies: $1,300
- Office visits & procedures: $700
- Education: $300
- Laboratory tests: $100
- Vaccines, other preventive: $100

#### Total: $5,400

#### Patient pays:
- Deductible: $0
- Co-pays: $1,160
- Co-insurance: $0
- Limits or exclusions: $280

#### Total: $1,440

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?
☒ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
☒ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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### Miami-Dade County Public Schools: LocalPlus

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2015 - 12/31/2015

**Coverage for:** Individual/Individual + Family | Plan Type: OAP

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**LocalPlus Plan**

**Questions:** Call 1-800-806-3052 or visit us at www.myCigna.com.

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### Important Questions

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<th>Answers</th>
<th>Why this Matters:</th>
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<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>For in-network providers $750 person / $1,500 family</td>
<td>You must pay all the costs up to the deductable amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductable starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductable.</td>
</tr>
<tr>
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<td>For out-of-network providers $1,500 person / $3,000 family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does not apply to in-network preventive care, in-network office visits, emergency room visits, urgent care facility visits, prescription drugs</td>
<td></td>
</tr>
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<td></td>
<td>Co-payments don't count toward the deductable.</td>
<td></td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. For in-network providers $4,000 person / $8,000 person / $16,000 family</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for healthcare expenses.</td>
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<td></td>
<td>For out-of-network providers $8,000 person / $16,000 family</td>
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<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover.</td>
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<td>No.</td>
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<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. For a list of participating providers, see <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-806-3052</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
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<td>Yes.</td>
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**Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

**Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

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<td>Out-of-Network Provider</td>
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<td></td>
</tr>
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<td>Primary care visit to treat an injury or illness</td>
<td>$20 co-pay/visit</td>
<td>50% co-insurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$50 co-pay/visit</td>
<td>50% co-insurance</td>
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<tr>
<td>Other practitioner office visit</td>
<td>$50 co-pay/visit for chiropractor</td>
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<td>Hospital Based or Affiliated: 30% co-insurance/x-ray</td>
<td>No Charge/blood work</td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 co-pay per type of scan/day at Non-Hospital Based 30% co-insurance/Hospital Based or Affiliated</td>
<td>50% co-insurance</td>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$15 co-pay/prescription (retail), $30 co-pay/prescription (home delivery) Preventive Generic-(preventive medication listing): $15 co-pay/prescription (home delivery)</td>
<td>50% co-insurance</td>
<td>Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$40 co-pay/prescription (retail), $80 co-pay/prescription (home delivery)</td>
<td>50% co-insurance</td>
<td>Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% co-insurance/prescription with $100 minimum/ $150 maximum (retail), 50% co-insurance/prescription with $200 minimum/ $300 maximum (home delivery)</td>
<td>50% co-insurance</td>
<td>Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (home delivery)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% co-insurance/Hospital Based or Affiliated</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$300 co-pay/visit/$150 co-pay/visit at JMH Facilities (Memorial, North &amp; South)</td>
<td>$300 co-pay/visit/$150 co-pay/visit at JMH Facilities (Memorial, North &amp; South)</td>
<td>Per visit co-pay is waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$50 co-pay</td>
<td>$50 co-pay</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$70 co-pay/visit</td>
<td>$70 co-pay/visit</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-806-3052 or visit us at www.myCigna.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-806-3052 to request a copy.
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services $20 co-pay/office visit and No Charge/other outpatient services</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services 30% co-insurance after plan deductible</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services $20 co-pay/office visit and No Charge/other outpatient services</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services 30% co-insurance after plan deductible</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Prenatal and postnatal care No Charge</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services 30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care 30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for failure to precertify. Coverage for Rehabilitation, including Cardiac rehab, services is limited to 40 days annual max per therapy.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services $50 co-pay/visit</td>
<td>50% co-insurance</td>
<td>50% penalty for failure to precertify. Coverage for Rehabilitation, including Cardiac rehab, services is limited to 40 days annual max per therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services Not Covered</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care 30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment 30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Hospice services 30% co-insurance</td>
<td>50% co-insurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye Exam Not Covered</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Glasses Not Covered</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
<tr>
<td></td>
<td>Dental check-up Not Covered</td>
<td>Not Covered</td>
<td>-----------none-----------</td>
</tr>
</tbody>
</table>

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Excluded Services & Other Covered Services

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

<table>
<thead>
<tr>
<th>Services</th>
<th>Services</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Habilitation services</td>
<td>Routine foot care</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Hearing aids</td>
<td>Weight loss programs</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>Long-term care</td>
<td></td>
</tr>
<tr>
<td>Dental care (Adult)</td>
<td>Non-emergency care when traveling outside the U.S.</td>
<td></td>
</tr>
<tr>
<td>Dental care (Children)</td>
<td>Private-duty nursing</td>
<td></td>
</tr>
<tr>
<td>Eye care (Children)</td>
<td>Routine eye care (Adult)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Infertility treatment</td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-806-3052. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-806-3052. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-244-6224.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page----------
Coverage Examples
About these Coverage Examples:
These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.
Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount owed to providers: $7,540</td>
<td>Amount owed to providers: $5,400</td>
</tr>
<tr>
<td>Plan pays: $4,920</td>
<td>Plan pays: $4,040</td>
</tr>
<tr>
<td>Patient pays: $2,620</td>
<td>Patient pays: $1,360</td>
</tr>
</tbody>
</table>

Sample care costs:

- Hospital charges (mother): $2,700
- Routine Obstetric Care: $2,100
- Hospital charges (baby): $900
- Anesthesia: $900
- Laboratory tests: $500
- Prescriptions: $200
- Radiology: $200
- Vaccines, other preventive: $40
- **Total**: $7,540

Patient pays:

- Deductible: $750
- Co-pays: $100
- Co-insurance: $1,740
- Limits or exclusions: $30
- **Total**: $2,620

Sample care costs:

- Prescriptions: $2,900
- Medical equipment and supplies: $1,300
- Office visits & procedures: $700
- Education: $300
- Laboratory tests: $100
- Vaccines, other preventive: $100
- **Total**: $5,400

Patient pays:

- Deductible: $0
- Co-pays: $1,080
- Co-insurance: $0
- Limits or exclusions: $280
- **Total**: $1,360

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7 of 8
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?
- No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
- No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 122518 BenefitVersion: 3
Plan Name: LocalPlus

Questions: Call 1-800-806-3052 or visit us at www.myCigna.com.
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Preventive medications are used for the prevention of conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack, stroke and prenatal nutrient deficiency.

You may not have to pay a copay, a coinsurance (the percentage you pay after you meet your deductible) and/or a deductible (the amount you pay before your plan starts to pay) for preventive generic medications. For some, the cost of generic preventive medications may be covered 100% by your pharmacy benefits plan. Please check your plan materials to understand how preventive medications are covered for you.

Following is a list of preventive generic medications arranged by type of condition.

Please note: this list is subject to change. You can also refer to myCigna.com for a complete and up-to-date drug listing where preventive medications are indicated with a “PM” symbol after the drug name. The Prescription Drug Price Quote tool on myCigna.com is available to help you find drug costs for preventive medications covered under your plan.

Health care reform and you

The Patient Protection and Affordable Care Act (PPACA), commonly referred to as “health care reform,” was signed into law on March 23, 2010. This important legislation will result in changes to every American’s health coverage. Some of the changes took effect in 2010 and most of the law’s effects will be felt by 2014. Cigna will comply with all provisions of the law including those that impact your pharmacy coverage plan. For example, depending upon the final government regulations, coverage for medications that have not traditionally been included in pharmacy plans, such as specific over-the-counter (OTC) medications, may be made available at no cost share to you.

As with all covered medications, we would require a prescription from your doctor to process the claim under your pharmacy plan (including OTC medications).

To get the most current information about preventive medications that may be available at no cost to you, visit www.informedonreform.com or Cigna.com and look for the “Informed on Reform” link.
Healthcare Benefits

preventive generics drug list

**ASTHMA RELATED**
- albuterol sulfate
- aminophylline
- budesonide
- caffeine citrate
- cromolyn sodium
  (inhalation solution)
- diprophylline
- guaifenesin/diprophylline
- ipratropium bromide
- levallbuterol
- levallbuterol HCl
- metaproterenol sulfate
- montelukast
- racpinephrine HCl
- terbutaline sulfate
- theophylline anhydrous
- zafirlukast

**BLOOD PRESSURE RELATED**
- acebutolol HCl
- acetazolamide
- amiloride HCl
- amlodipine besylate
- amlodipine besylate/benazepril
- amlodipine/atorvastatin
- atenolol
- benazepril HCl
- bendroflumethiazide/hydrochlorothiazide
- betaxolol HCl
- bisoprolol fumarate
- bisoprolol/HCTZ
- bumetanide
- candesartan/HCTZ
- captopril
- captopril/HCTZ
- carvedilol
- chlorothiazide
- chlorthalidone
- chlorthalidone/atenolol
- clonidine HCl
- clonidine HCl/chlorthalidone
- diltiazem
- diltiazem HCl
- Driuril
- doxazosin mesylate
- enalapril maleate
- enalapril maleate/HCTZ
- eplerenone
- eprosartan
- eprosartan mesylate
- felodipine
- fosinopril
- fosinopril sodium
- fosinopril/HCTZ
- furosemide
- guanabenz
- guanfacine HCl
- hydrochlorothiazide
- hydrochlorothiazide/amilor HCl
- indapamide
- irbesartan
- irbesartan/HCTZ
- isradipine
- labetalol HCl
- lisinopril
- lisinopril/HCTZ
- losartan
- losartan/HCTZ
- methazolamide
- methylclosporin
- methyldopa
- metoclopramide
- metolazone
- metoprolol succinate
- metoprolol tartrate
- metoprolol/HCTZ
- minoxidil
- moexipril HCl
- moexipril HCl/HCTZ
- nadolol
- nicardipine HCl
- nifedipine
- nimodipine
- nisoldipine
- perindopril
- pindolol
- prazosin HCl
- propranolol HCl
- propranolol/HCTZ
- quinapril
- quinapril HCl/HCTZ
- ramipril
- reserpine
- reserpine/HCTZ
- sotalol HCl
- spironolactone
- spironolactone/HCTZ
- telmisartan/HCTZ
- terazosin HCl
- timolol maleate
- torsemide
- trandolapril
- triamterene/HCTZ
- valsartan
- valsartan/HCTZ
- Vecamyl-mecamylamine HCl
- verapamil
- verapamil SR

**BLOOD THINNER**
- cilostazol
- clopidogrel bisulfate
- dipyridamole
- ticlopidine HCl
- warfarin

**CHOLESTEROL RELATED**
- amlodipine/atorvastatin
- atorvastatin
- cholestyramine/aspartame
- cholestyramine/sucrose
- colestipol HCl
- fenofibrate
- fenofibrate, micronized
- fenofibric acid
- fluvastatin
- gemfibrozil
- lovastatin
- niacin
- omega-3 acid ethyl esters
- pravastatin sodium
- simvastatin

**DIABETES RELATED**
- acarbose
- chlorpropamide
- glimepiride
- glipizide
- glipizide ER
- glipizide/metformin HCl
- glyburide
- glyburide, micronized
- glyburide/metformin
- metformin HCl
- nateglinide
- pioglitazone HCl
- repaglinide
- tolazamide
- tolbutamide

**OSTEOPOROSIS RELATED**
- alendronate sodium
- etidronate
- Fortical (calcitonin-salmon)
- ibandronate sodium
- raloxifene HCl

**REPRESENTATIVE PRENATAL VITAMINS**
*All prescription strength generic prenatal vitamins qualify as preventive medications*
It's easier and better than ever. Most important, you are in control when searching Find Docs & Services on myCigna.com. And your search results are personalized according to your health plan. So you get the information you need to make the right decisions for you and your family.

**Smarter searching results in cost and quality information like never before.**

- **Personalized search capability** to easily find the right doctors and facilities for you. Don't know your doctor's specialty? No problem. myCigna.com will help you find the right doctor without confusing medical titles. Too many doctors to choose from? Refine your search. It's as easy as moving the distance range and clicking on Cigna Care Designations or whatever criteria you need.

- **Quality distinctions and cost-efficiency ratings of doctors** with every result, with quality-designated doctors appearing first on your list.

- **Compare out-of-pocket estimates** — specific to your coverage plan — for actual treatment and procedure costs. And, out-of-pocket estimates calculate your deductible, the percentage you pay (coinsurance) and any account balances on that given day.

- **Estimates show both doctor and facility fees** in one place, allowing you to more accurately compare total costs of treatment before choosing your doctor and where to receive care.
Comparison information.

Compare what matters most before you select your doctor.

And now you can access myCigna.com from any smartphone or web-enabled mobile device.* With the myCigna Mobile App, it's never been easier to be on the go and in the know.

*Actual features may vary based on your plan and your individual security profile. The downloading and use of the myCigna Mobile App is subject to the terms and conditions of the App and the online stores from which it is downloaded. The myCigna Mobile App is available to any current Cigna customer who has been provided user access to myCigna.com. The listing of a health care professional in the myCigna Mobile App directory does not guarantee that the services rendered by that professional are covered under your specific medical plan. Check your official plan documents, or call the number listed on your ID card for information about the services covered under your plan benefits.

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Standard mobile phone carrier and data usage charges apply. Cigna’s mobile web solution is available to any current Cigna customer (who has been provided user access to myCigna.com, which includes the personalized Health Care Provider (HCP) directory, contact info and Prescription Drug Price Quote Tool (if your plan includes prescription drug coverage through Cigna). Cigna’s mobile HCP directory is also available at myCigna.com. The listing of HCP in the mobile directories available at myCigna.com and Cigna.com does not guarantee that the services rendered by that professional are covered under your specific medical plan. Check your official plan documents, or call the number listed on your ID card for information about the services covered under your plan benefits.

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806692 | 11/13 © 2013 Cigna. Some content provided under license.
Cigna care management is designed to help you access the services that are most appropriate for you. Through precertification (finding out in advance if a service is covered) and nurse case managers, Cigna can help you lower costs, avoid unnecessary procedures and support you as you recover after a procedure.

What does care management mean for you?

1. **Ease.** When you or a covered family member receives care from a participating Cigna doctor or facility, your doctor arranges all the care and gets precertification when it’s needed. It’s hassle-free for you. (You’re responsible for getting precertification for care you receive from an out-of-network doctor or facility.)

2. **Savings.** We look for smart ways to help you save money by reviewing inpatient and outpatient services. We may be able to lower your out-of-pocket costs by recommending one of our preferred facilities, transitioning inpatient care to outpatient treatment, or helping identify treatments or procedures that may be avoidable.

3. **Quality of Care.** You’ll have access to nurse case managers who can help you find the support you need to get better. This includes home health care, therapies or special medical needs to help you avoid complications after a hospital stay or outpatient procedure. And, our service quality is proven – our customers report an over 95% overall satisfaction rating with their case management experience.

What is precertification?

Precertification is the process of determining in advance whether a procedure, treatment or service will be covered under your health care plan. It also helps ensure you get the right care in the right setting – potentially saving you from costly and unnecessary services.

Who is responsible for getting the precertification?

- **In-network services:** Your doctor is responsible.
- **Out-of-network services:** You’re responsible if you choose to see an out-of-network doctor and your plan covers out-of-network services. To get precertification, call the toll-free number on your Cigna ID card. You’ll need the name of the doctor or facility, the procedure or procedure code and the date of service when you call. Remember, when you go out-of-network, your out-of-pocket costs will be higher and your coverage may be reduced or denied if you don’t get precertification.
## What services need to be precertified?

Your doctor will help you decide which procedures require a hospital stay and which can be handled on an outpatient basis. Inpatient services include procedures, treatments and services that you receive in a hospital or related facility that require you to stay overnight. Outpatient services don’t require an overnight stay. Here are some examples of services requiring precertification:

<table>
<thead>
<tr>
<th>Inpatient services</th>
<th>Outpatient services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All inpatient admissions and non-obstetric observation stays such as:</td>
<td>• Certain outpatient surgical procedures</td>
</tr>
<tr>
<td>- Acute hospitals</td>
<td>• High-tech radiology (MRI, CAT scans, PET scans)</td>
</tr>
<tr>
<td>- Skilled nursing facilities</td>
<td>• Injectable drugs (other than self-injectibles)</td>
</tr>
<tr>
<td>- Rehabilitation facilities</td>
<td>• Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)</td>
</tr>
<tr>
<td>- Long-term acute care facilities</td>
<td>• Home health care/home infusion therapy</td>
</tr>
<tr>
<td>- Hospice care</td>
<td>• Dialysis (to direct to a participating facility)</td>
</tr>
<tr>
<td>- Transfers between inpatient facilities</td>
<td>• External prosthetic appliances</td>
</tr>
<tr>
<td>• Experimental and investigational procedures</td>
<td>• Speech therapy</td>
</tr>
<tr>
<td>• Cosmetic procedures</td>
<td>• Cosmetic or reconstructive procedures</td>
</tr>
<tr>
<td>• Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean</td>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>section)</td>
<td>• Diagnostic cardiology</td>
</tr>
<tr>
<td></td>
<td>• Radiation therapy</td>
</tr>
</tbody>
</table>

*This list does not include all services requiring precertification.*

## What other services are available to me?

If you or a covered family member needs care beyond a traditional hospital stay, our experienced nurse case managers work closely with you and your doctor to help you sort out your options, arrange care, or access helpful community resources and programs. Whether your need is for home care, explaining your medications or finding additional services, your case manager helps you find the care you need to help you get better.

## What if I have questions about my coverage?

Visit myCigna.com or call the toll-free number on your Cigna ID card.

## Using the Cigna network saves time and money

With many of our plans, you may choose the doctors you see and where you want to receive care. However, choosing doctors and facilities that participate in the Cigna network can help you keep your out-of-pocket costs down and you won’t have to arrange care or file claims. Your in-network doctor will take care of that for you.

To find a participating doctor, use the provider directory on myCigna.com. There, you’ll find complete physician profiles, including education, languages spoken, hospital affiliations, and detailed maps with directions. Online tools will also help you find estimated average cost ranges for common procedures, medical services and conditions – all to help you save money and make the best choice for your needs.
myCigna.com

Register today. It’s this easy:

1. Go to myCigna.com and select “Register.”
2. Enter your personal details like name, address and date of birth.
3. Confirm your identity with secure information like your Cigna ID, social security number or a security question. This will make sure only you can access your information.
4. Create a user ID and password.
5. Review and submit.

Now you’re ready to log in to your personal, secure myCigna.com site. See how the site has been redesigned with you in mind, making it easy to navigate and find what you need:

- Search for a claim
- Find a doctor
- Manage and track your health information

It’s a whole new world of online service.
Simple format.
See how your benefits are working for you with this easy-to-understand document. It shows you the costs associated with the medical care you’ve received. When a claim is filed under your Cigna benefits plan, you get an Explanation of benefits (EOB). Because we know health care expenses can be confusing, we’ve simplified the language and summarized the most important information about the claim.

The choice is yours: online, paper or both.
Your EOB is now online at myCigna.com. You can choose to go paperless, continue getting paper EOBs by mail or opt for both.

Online EOBs are:
• Safely stored on myCigna.com.
• Easy to access anywhere, 24 hours a day.
• Printable from your computer if you need a paper copy.

The Summary page gives an overview of the ways your benefits are working for you—quickly see what was submitted, what’s been paid and what you owe.

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

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

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

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**Page 1 Summary**

**Cigna.**

Cigna Health and Life Insurance Company

Explanation of benefits
for a claim received for YOUR NAME, Reference # 865999999999999

Summary of a claim for services on November 9, 2012
for services provided by Wellbeing, I, MD

<table>
<thead>
<tr>
<th>Amount billed</th>
<th>$189.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount</td>
<td>$70.05</td>
</tr>
<tr>
<td>Amount not covered</td>
<td>$0.00</td>
</tr>
<tr>
<td>What Cigna plan paid</td>
<td>$107.06</td>
</tr>
</tbody>
</table>

**What I owe**

$11.89

**You saved**

94%

This was the amount that was billed for your visit on 11/09/2012. You saved $70.05. Cigna negotiates discounts with health care professionals and facilities to help you save money.

This is the portion of your bill that’s not covered by your Cigna plan. You may or may not need to pay this amount. See the Notes section on the following pages for more information.

Cigna paid $107.06 to Wellbeing, I, MD on 11/18/2012.

This is the amount you owe after your discount, what your Cigna plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid when you received care may reduce the amount you owe.

You saved $177.11 (or 94%) off the total amount billed. This is a total of your discount and what your Cigna plan paid. To maximize your savings, visit www.myCigna.com or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.

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832701 c 02/13

Offered by: Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company.
This information page is for all groups.

Guide to Your Explanation of Benefits

PAGE 2 GLOSSARY

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

Glossary
- Amount billed: The amount charged by the health care provider.
- Amount not covered: The portion of the amount billed that is not covered by insurance.

Your Rights of review and appeal will help you figure out what to do if you disagree with any of the benefit decisions made on this claim.

Rights of review and appeal
- If you have any questions about this explanation of benefits, you can contact Cigna.
- If you are not satisfied with the decision, you can appeal.

PAGE 3 CLAIMS

The Claims detail page follows the Glossary page. Here, you’ll find:

- The dollar amount and percentage Cigna paid toward the covered amount, minus any copay/deductible you’re responsible for.
- The portion of covered expenses you’re responsible for paying. For example, if your Cigna plan covers 80% of the covered amount, you pay the remaining 20%.

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

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

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

Claim detail
Cigna Claim Number: 09999999999999

- Claim date: September 15, 2012
- Claim status: Finalized

- Benefits paid: $3,544.00
- Total charge: $17,800.00
- Total deductible: $0.00

- Covered expenses: $11,800.00
- Responsibility: $5,976.00

What you need to know for your next claim:
- Review the explanation of benefits before filing a claim.
- Check the claim status online or call Cigna.

Other important information that you need to know:
- Cigna’s in-network providers can help you save money.
- Out-of-network providers may be more expensive.

Notes:
- This is not a bill. It is an explanation of benefits. It shows the amounts paid and credits and the amounts you have remaining in your deductible and your out-of-pocket maximum.

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Ten easy ways to lower your out-of-pocket health care expenses

1. **Stay in network.** Save big when you use a doctor, hospital or facility that’s part of the Cigna network. Chances are, there’s a network doctor or facility in your neighborhood. It’s easy to find quality, cost-effective care right where you need it. In fact, one thing you won’t find is higher costs.

2. **Ask before you go.** Your primary care doctor may be in your plan’s network, but that doesn’t mean everyone and everywhere they refer you to is, too. When your doctor gives you a referral, don’t be afraid to ask if the facility, lab or specialist is in your plan’s network. If you don’t, you may unintentionally go out of network and be surprised by a higher bill than expected.

3. **Know your plan – inside and out.** If you go out of network for care, the costs can add up quickly. That’s because you’re paying full price – not the discounted price an in-network doctor or facility would charge for services covered under your plan. Plus, if the doctor or facility charges more than what your plan will pay for out-of-network care, you will have to pay the difference.

4. **Go with the Cigna Care Designation.** You may save even more when you choose a Cigna Care Designation doctor or a Centers of Excellence hospital. Doctors in 22 medical specialties, including primary care, who achieve top results on our measures of health outcomes and cost-efficiency earn the Cigna Care Designation. Centers of Excellence hospitals have also earned recognition for quality and cost-efficiency for certain procedures. Look for these designations in the online directory.

5. **Get preventive care.** Checkups, immunizations and screenings can help detect or prevent serious diseases and keep you in tip-top shape. Your primary care physician can help you coordinate what tests and shots are right for you, based on your age, gender and family history.

Need to find a doctor, hospital or other care facility? Use the online directory on myCigna.com or call the number on your Cigna ID card.

Offered by: Connecticut General Life Insurance Company Cigna Health and Life Insurance Company, or their affiliates.
Healthcare Benefits

6. **Use an urgent care center.** If you need medical attention but it’s not serious or life threatening, you may not have to go to an emergency room (ER). An urgent care center provides quality care like an ER, but can save you hundreds of dollars. Visit an urgent care center for things like minor cuts, burns and sprains, fever and flu symptoms, joint or lower back and urinary tract infections.

   Average urgent care center cost: * $135
   Average hospital ER cost: $1,553

7. **Go to a convenience care clinic.** Need to see your doctor but can’t get an appointment? Try going to a convenience care clinic. You’ll get quick access to quality and cost-effective medical care. A convenience care clinician can treat you for sinus infections, rashes, earaches, minor burns and other routine medical conditions. You can find convenience care clinics in grocery stores, pharmacies and other retail stores.

   Average convenience care clinic cost: $58
   Average ER cost: $1,553

8. **Stick with lower-cost labs.** If you go to a national lab such as Quest Diagnostics® or Laboratory Corporation of America® (LabCorp), you can get the same quality service and save up to 84%.** Even though other labs may be part of the Cigna network, you’ll often get even bigger savings when you go to a national lab. And with hundreds of locations nationwide, they make it easy to get lab services at a lower cost.

   Average Quest or LabCorp cost: $10.55
   Average other lab cost: $23.89
   Average outpatient hospital lab cost: $51.47

9. **Visit independent radiology centers.** If you need a CT scan or MRI, you could save hundreds of dollars by going to an independent radiology center. These centers can provide you with quality service like you’d get at a hospital, but usually at a lower price.

   Average radiology center cost: CT $445, MRI $725
   Average outpatient hospital costs: $1,384, $1,668

10. **Choose the right place for your colonoscopy, GI endoscopy or arthroscopy.** When you choose to have one of these procedures at an in-network freestanding outpatient surgery center, you could save hundreds of dollars. These facilities specialize in certain types of outpatient procedures, and offer quality care, just like a hospital, but at a lower cost to you.

   Average outpatient surgery center: $959
   Average hospital cost: $2,548

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Access the online directory and manage your health spending on myCigna.com with the myCigna Mobile App.
Download it today from the App Store™ online store or Google Play™

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*Cost estimates are national 2012 averages of participating facilities, actual cost may vary by location, facility, and the type or level of services received.

**Savings estimate is based on an internal Cigna national study of 2012 lab utilization data, costs and discounts. Savings will vary.

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The information provided here is intended to be general information on how you can get the most out of your plan and your health care dollars. Customers are encouraged to consider all relevant factors and to consult with their treating doctor when selecting a health care professional or facility for care. Cost and quality ratings or designations provide you with important information you may wish to consider as you decide where to receive care. This information should not be used to make final decisions about your care and is not a guarantee of the quality of care delivered to individual patients. Health care professionals and facilities that participate in the Cigna network are independent contractors solely responsible for the care they deliver and not agents of Cigna.

All health insurance and health benefit plans have exclusions and limitations. For costs and a complete list of both covered and non-covered services, see your official plan documents.

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Why is Cigna calling me?
Your employer offers you Cigna programs to help you get healthy and live well. We’re excited to get to know you, so we call you at home to talk about ways we can work together to help you manage your health.

Why do I get so many phone calls?
Your employer may offer you many different Cigna health programs, so you may receive calls from different Cigna specialists. They are all equally important, and designed to help in different ways.

Why should I answer the call?
Cigna’s here to help you manage your health however you need us, but we can’t help if you don’t pick up. When we call, we want to start a conversation so we can learn what’s important to you – whether that’s a chronic condition, making healthy choices, or filling a prescription. You may also be eligible for incentives for your participation.

If you aren’t able to answer the call right away, feel free to call when you have time. Our coaching programs are open for coaching appointments during the day and the evenings. Someone is always available to answer any immediate questions you have about your health. Every phone call is private and confidential. We always talk in easy-to-understand terms. And we’re not trying to sell you anything – we’re just calling to help you live a healthier life.

What happens on the call?
When you answer, you’ll be connected with a health advocate who will tell you their name and why they’re calling. They will help you determine the best way Cigna can assist you. If you decide you want to join the program, you’ll set up an appointment for your first coaching call. Free 1:1 coaching begins during the first coaching session.

Sometimes, we use an automated calling system to reach out to you. This is not a telemarketing service. We’ll ask you a few questions, then connect you with a live health advocate so you can make a coaching appointment and get started working on your health goals.

Is it private?
Yes. Every call is private and confidential.

Why do you use an automated phone system?
To make a quick connection with you – like reminding you about an appointment or verifying your personal information before connecting you with a health advocate. You can always request to talk to a live health advocate at any time.

Do I have to wait for you to call me?
No! We’re happy you want to get started taking steps on the path to health right away. You can call us any time, day or night, by dialing the number on the back of your ID card. We’re available 24/7 to serve you, but only do coaching calls during working hours. If you call late at night or early in the morning, we’ll help you schedule a call during a time your health advocate is available.
What if I don’t want to get any more phone calls?
Ask the Cigna caller to remove you from the contact list, or call the number on the back of your ID card and ask for customer service.

What programs might you call me about?
Below is a list of programs we might call you about. These are programs your employer has chosen to help you take steps toward a healthier life, and you may be eligible for an incentive when you participate. We do our best to suggest programs you might be interested in by listening to you and looking at information like your health assessment answers, claim information, or if you miss preventive care a like incentive when you participate. We do our best to suggest programs you might be interested in by listening to you and looking at information like your health assessment answers, claim information, or if you miss preventive care a like incentive when you participate. We do our best to suggest programs you might be interested in by listening to you and looking at information like your health assessment answers, claim information, or if you miss preventive care a like incentive when you participate. We do our best to suggest programs you might be interested in by listening to you and looking at information like your health assessment answers, claim information, or if you miss preventive care a like incentive when you participate. We do our best to suggest programs you might be interested in by listening to you and looking at information like your health assessment answers, claim information, or if you miss preventive care a like incentive when you participate.

STRESS, WEIGHT & TOBACCO <Use this if client has all 3 programs>
You’ll be connected to a health advocate who will work with you to create a personalized plan to quit smoking, maintain a healthier weight, or manage your stress.

<Use these as appropriate if client offers only one or two programs>

TOBACCO
You’ll be connected to a health advocate who will work with you to create a personalized program to help you quit using tobacco.

WEIGHT MANAGEMENT
You’ll be connected to a health advocate who will work with you to create a personalized program to help you maintain a healthier weight.

STRESS MANAGEMENT
You’ll be connected to a health advocate who will work with you to create a personalized program to help you manage your stress.

HEALTH COACHING, TREATMENT DECISION SUPPORT OR CLOSING GAPS IN CARE <Use this if client has Health Advisor (Coaching, TDS and GIC)
You may receive a call to verify personal information about a specific condition. Then, you’ll be connected to a health advocate who will help you get started.

Your health advocate will help you understand your condition, discuss treatment options, remind you to refill your prescription, visit your doctor or follow-up on other forms of care, or just help you learn how to develop healthier habits for a healthier you.

CHRONIC CONDITION SUPPORT <Use this if client has YHF>
If you have a chronic condition, Cigna may be notified if you miss care you should have received based on evidence-based guidelines. If this happens, we might call you to talk about ways we can help you manage your care and your condition.

Your health advocate will help you create a personal care plan, understand medications or your doctor’s orders, identify triggers that affect your condition, learn your treatment options and know what to expect if you need to spend time in the hospital.

COACHING TO CLOSE GAPS IN CARE
At Cigna, we want to help you do everything you can to improve or maintain your health. If we notice that you’ve missed a doctor’s appointment in your care plan, haven’t refilled a prescription or have had a gap in your care that could affect your health, we may start a conversation about gaps during a regular coaching call to see how we can help.

CASE MANAGEMENT
If you’re already taking part in Cigna’s Case Management program, you’ll continue to receive your regular calls. If there’s been a gap in your care that could affect your health, your case manager may bring it up during your regular call.

CIGNA PHARMACY
If you’ve signed up for Cigna’s CoachRx Service or participate in TheraCare, you may get calls that remind you to fill your prescription medication or calls from your personalized therapy support coordinators. You may also get calls explaining the benefits of filling your prescriptions at Cigna Home Delivery Pharmacy. If you already fill your prescriptions through Cigna Home Delivery Pharmacy, you may get calls regarding your order status, refills and prescription renewals.

DISABILITY <Use this if Client offers Cigna Group Insurance>
If you’re on short term disability, we’ll call you when your claim is approved and talk about following up throughout your leave. If you’re on long-term disability, we might call to help you learn about programs and resources that can help you return to work.

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

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

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

Benefits from the Comprehensive Transplant Case Management Unit include:
- Clinical partnership with providers
- Consistency in service and benefit administration
- Dedicated resources for complex areas of medicine
- Advocacy
- Administrative efficiency

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

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

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

Not all CIGNA LIFESOURCE Transplant Network facilities are available to members in all plans. Please call Member Services at 800.668.9682 for more information. If you are already in transplant case management, please call your case manager directly.
Spend Less On Prescription Medications
As consumers, we often price shop to get the best value for our dollar. But you may not realize that you can also compare prices for prescription medications. There are often many medications that treat a particular illness. The medications may be equally effective, but their costs can vary greatly. Here are some tips on how to save money on prescription medications by choosing medications that offer better health value and cost less.

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

- Go to myCigna.com after January 1, 2015 or www.Cigna.com and click on “Drug Lists” to price medications and make note of your lowest cost options. Ask your doctor if they are appropriate for your treatment.
- Ask your doctor or pharmacist if a less expensive alternative is available.
- Call the customer service number on your ID card and ask the representative to check for lower cost options.

What’s a narrow retail pharmacy network?
This is a network or participating pharmacy where prescriptions can be filled. All other pharmacies are not participating in the plan.

Which pharmacies are participating in the plan?
Only Walgreens, Walmart, Publix, Navarro and specifically identified, independent pharmacies in the network.

Consider Pharmacies That Offer Discounts on Generics
Some retail pharmacies offer very low prices on select generic drugs—often less than your usual co-payment—and include commonly prescribed generic medications for several conditions such as asthma, anxiety, high blood pressure and infections (antibiotics).

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

>> 2015 Prescription Enhancements:
- Generic seven drug classes 1-month co-payment for a 90-day supply via the mail-away program
- Educational initiatives regarding enhanced pharmaceutical benefits.
Ask About Over-the-Counter (OTC) Alternatives

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

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

To obtain a list of medications included in discount programs, you can log on to the local pharmacies’ websites listed below.

Pharmacy options outside your healthcare plan

You have an alternative pharmaceutical choice outside your School Board healthcare plan that can save you money. Hundreds of prescriptions are offered at a lower co-payment for a 30-day and 90-day supply. These programs offer you coverage for most generics and some brand-name medications.

The following participating pharmacies offer you these alternative programs:

- Walmart  www.walmart.com/cp/5431
- Target    www.target.com/pharmacy/generics
- Walgreens www.walgreens.com/pharmacy
- Publix    www.publix.com/pharmacy/Free-Medications.do

**Publix:**

- **FREE Prescriptions:**
  - Lisinopril for a 30-day supply up to 60 tablets
  - Antibiotics for up to a 14-day supply for the following generics:
    - Amoxicillin
    - Ampicillin
    - Cephalexin (capsules and suspension only)
    - Sulfamethoxazole/Trimethoprim (SMZ-TMP)
    - Ciprofloxacin (excluding Ciprofloxacin XR)
    - Penicillin VK
  - Metformin for up to a 30-day supply (90 tablets) of generic immediate-release (500 mg, 850 mg and 1,000 mg)

Alternative Prescription Options Outside Your Healthcare Plan

The following pages provide you information regarding prescription programs outside of your School Board-sponsored healthcare plan.

These programs are not sponsored by M-DCPS; they do provide you a wide range of generics to help treat a variety of conditions and diseases. Therefore, the District encourages you to take advantage of the savings and convenience.

Money Saving Tip:

**Know what medicines may be offered FREE at certain retail pharmacies in your area.**
Declination of Healthcare Coverage Affidavit

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided through Miami-Dade County Public Schools (M-DCPS).
2. The benefits of the plans have been thoroughly explained to me, and I decline to participate.
3. I have other group or state-funded medical coverage currently in effect (not a School Board-sponsored plan).
4. I understand that if I desire to apply for medical insurance at a later date, I may enroll only during an annual enrollment period determined by M-DCPS or during a "special enrollment period" (Change in Status) following an IRS acceptable change in status event. For example, you may in the future, be able to enroll yourself or your dependents in a group medical plan through the School Board if you or your dependents lose coverage under an existing employer provided medical plan, provided that you request enrollment within 30 days after your other group product coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption (or placement for adoption), you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the event. In case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for cause or as a result of failure to pay any contributions toward the cost of coverage on a timely basis.

NOTE: Internal Revenue Service (IRS) guidelines state that the loss of insurance through an individual healthcare plan does not constitute a valid Change in Status event.

5. I understand that I will not be enrolled in a Board-Paid medical plan. I will receive Board-Paid Standard Short-Term Disability and will receive $100 per month, paid through the payroll system. (This may be subject to withholdings and FICA.)
6. I understand that I must provide proof of other group healthcare coverage. Otherwise, I understand that I will be auto-assigned Cigna LocalPlus Plan (employee-only) coverage.

I have read, understand and agree to comply with the requirements stated above.
Additionally, proof of other group or state funded healthcare plan coverage is being submitted with this Affidavit.

Print Name

Employee Number

Signature

Date

This Affidavit must be submitted with proof of other group or state-funded healthcare coverage, even if previously submitted. Please fax this affidavit and proof of other group healthcare coverage to 305.995.1425.
Florida KidCare

Florida KidCare offers free to low-cost comprehensive health coverage for children.

Your child may be eligible for health insurance through Florida KidCare, even if one or both parents are working. Getting health insurance for your children before they get sick is very important. The Florida KidCare program provides children with comprehensive health coverage from birth through age 18.

Florida KidCare Benefits include:
- Doctors’ Visits
- Check ups
- Shots
- Hospital Admission
- Surgery
- Prescriptions
- Emergencies
- Mental Health
- Dental
- Vision and hearing

Eligibility for the Florida KidCare program is based on family size and household income. Many families pay $15 or $20 a month or nothing at all. Florida KidCare offers a full-pay option for families with children, ages 1-18 with higher incomes.

Here’s how to apply:

Online application
Visit www.floridakidcare.org and click “Apply Online Now.”

Paper application
Request a one-page application by calling 1.888.540.5437 (the call is free) or visit www.floridakidcare.org

Submit your completed application and documentation one of these ways:
- Fax application and documents to 1.866.867.0054 (the call is free)
- E-mail application and documents, as scanned attachments, to: apply@healthykids.org
- Mail application and documents to:
  Florida KidCare
  P.O. Box 980
  Tallahassee, FL 32302-0980

Eligibility Note:
Eligibility for the Florida KidCare program is based on family size and household income. Visit www.floridakidcare.org to apply online.

For additional information contact Barbara Biggart, KidCare Specialist at 1.305.995.1207, or by email at kidcare@daleschools.net
# Florida KidCare

<table>
<thead>
<tr>
<th><strong>Annual Deductibles And Maximums</strong></th>
<th><strong>KidCare</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime maximum</td>
<td>$1 million lifetime max</td>
</tr>
<tr>
<td>Pre-Existing Condition Limitation (PCL)</td>
<td>N/A</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>N/A</td>
</tr>
<tr>
<td>Maximum Reimbursable Charge</td>
<td>N/A</td>
</tr>
<tr>
<td>Calendar year plan deductible</td>
<td>N/A</td>
</tr>
<tr>
<td>Calendar year out-of-pocket maximum</td>
<td>N/A</td>
</tr>
<tr>
<td>Office Visit</td>
<td>PCP/Specialist $5 Co-pay Podiatry Visit $5 Co-pay</td>
</tr>
<tr>
<td>Physician Services (hospital)</td>
<td>1 Visit/Per Day/2 Months covered 100%</td>
</tr>
<tr>
<td>• In hospital visits and consultations</td>
<td></td>
</tr>
<tr>
<td>• Inpatient</td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td></td>
</tr>
</tbody>
</table>
# Florida KidCare

<table>
<thead>
<tr>
<th>Benefits</th>
<th>KidCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (in a physician's office)</td>
<td>PCP/Specialist, $5 Co-pay</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
</tr>
<tr>
<td>Children (to age 16)</td>
<td></td>
</tr>
<tr>
<td>• Includes well-baby and well-child</td>
<td></td>
</tr>
<tr>
<td>• Includes immunizations</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>• Includes lab and x-ray billed by the</td>
<td>100% Covered</td>
</tr>
<tr>
<td>doctor's office</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered after office visit Co-pay</td>
</tr>
<tr>
<td>PSA, Pap Smear Maternity Screening</td>
<td>100% Covered</td>
</tr>
<tr>
<td>• Coverage includes the associated</td>
<td></td>
</tr>
<tr>
<td>Preventive Outpatient Professional</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>• Diagnostic-related services are</td>
<td></td>
</tr>
<tr>
<td>covered at the same level of benefits</td>
<td></td>
</tr>
<tr>
<td>as other x-ray and lab services,</td>
<td></td>
</tr>
<tr>
<td>based on place of service</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Facility Services</td>
<td></td>
</tr>
<tr>
<td>Semi-private room and board and other</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>non-physician services</td>
<td>100% Covered</td>
</tr>
<tr>
<td>• Inpatient room and board, pharmacy,</td>
<td></td>
</tr>
<tr>
<td>x-ray, lab operating room, surgery,</td>
<td></td>
</tr>
<tr>
<td>etc.</td>
<td></td>
</tr>
<tr>
<td>• Private room stays may result in</td>
<td></td>
</tr>
<tr>
<td>extra charges for the patient.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>• For services performed by surgeons,</td>
<td>100% Covered</td>
</tr>
<tr>
<td>radiologists, pathologists and</td>
<td></td>
</tr>
<tr>
<td>anesthesiologists</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery (Facility Charges)</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>• For services performed by surgeons,</td>
<td></td>
</tr>
<tr>
<td>radiologists, pathologists and</td>
<td></td>
</tr>
<tr>
<td>anesthesiologists</td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational And Speech</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>Therapy</td>
<td>PT, OT, RT, ST</td>
</tr>
<tr>
<td></td>
<td>24 Treatments within 60 days per initial</td>
</tr>
<tr>
<td></td>
<td>episode</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$5 Co-pay, 24 visits per year</td>
</tr>
<tr>
<td>Laboratory (Includes Pre-Admission</td>
<td></td>
</tr>
<tr>
<td>Testing)</td>
<td></td>
</tr>
<tr>
<td>Lab</td>
<td>100% Covered</td>
</tr>
<tr>
<td>• Physician's Office</td>
<td>after office visit Co-pay $5</td>
</tr>
<tr>
<td>Lab</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>Lab, Emergency Room &amp; Urgent Care</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>Radiology Services (Includes Pre-</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>Admission Testing)</td>
<td></td>
</tr>
<tr>
<td>X-Ray</td>
<td>100% Covered - Test</td>
</tr>
<tr>
<td>• Physician's Office Visit</td>
<td></td>
</tr>
</tbody>
</table>
Florida KidCare

<table>
<thead>
<tr>
<th>Benefits</th>
<th>KidCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-Ray</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>• Outpatient Hospital Facility</td>
<td>100% Covered</td>
</tr>
<tr>
<td>• Independent X-Ray Facility, Hospital Based Or Affiliated</td>
<td></td>
</tr>
<tr>
<td>• Independent X-Ray Facility, Non-Hospital Or Affiliated</td>
<td></td>
</tr>
<tr>
<td>X-Ray, Emergency Room And Urgent Care</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (MRI, MRA, CAT Scan, PET Scan, Etc.)</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td></td>
<td>100% Covered</td>
</tr>
<tr>
<td><strong>Emergency And Urgent Care Services</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Inappropriate use of ER - $10 Co-pay (non emergencies)</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$10 Co-pay</td>
</tr>
<tr>
<td><strong>Other Health Care Facilities</strong></td>
<td>$0 Co-pay 100 Days per year</td>
</tr>
<tr>
<td>Skilled Nursing Facility, Rehabilitation Hospital And Other Facilities</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>$5 Co-pay Unlimited</td>
</tr>
<tr>
<td>Hospice</td>
<td>$5 Co-pay Unlimited</td>
</tr>
<tr>
<td><strong>Other Health Care Services</strong></td>
<td>$0 Co-pay 100% Covered Plan Approval Required</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
</tr>
<tr>
<td>• Unlimited Calendar Year Maximum</td>
<td></td>
</tr>
<tr>
<td>External prosthetic appliances (EPA)</td>
<td>No Co-pay for equipment and devices that are medically indicated to assist in the treatment of a medical condition and specifically prescribed as medically necessary by Enrollee's INSURER physician</td>
</tr>
<tr>
<td>TMJ, surgical and non-surgical</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maternity Care Services</td>
<td></td>
</tr>
<tr>
<td>• covers maternity for employee and all dependents. (Including Midwife Services)</td>
<td>3 days maximum limited to vaginal delivery</td>
</tr>
<tr>
<td>• Initial visit to confirm pregnancy</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>• Pre &amp; Post Natal Office Visits</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospital Facility</td>
<td>Family planning limited to one annual visit and one supply visit each ninety days.</td>
</tr>
</tbody>
</table>
# Florida KidCare

<table>
<thead>
<tr>
<th>Benefits</th>
<th>KidCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental Health Services</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td></td>
<td>100% Covered</td>
</tr>
<tr>
<td>Outpatient Mental Health Physician's Office Services</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td></td>
<td>100% Covered</td>
</tr>
<tr>
<td>Outpatient Mental Health Facility Services</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>Inpatient Substance Abuse Services</td>
<td>$0 Co-pay</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Physician's Office Services</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Facility Services</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$5 Co-pay up to 31 day supply</td>
</tr>
<tr>
<td></td>
<td>Brand name products are covered if a generic substitution is not available or where the prescribing physician indicates that a brand name is medically necessary.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$0 Co-pay - Vision</td>
</tr>
<tr>
<td></td>
<td>Hearing - No Co-pay for hearing screening by primary care physician.</td>
</tr>
</tbody>
</table>

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## Money Saving Tip:

Florida Kidcare offers free to low-cost comprehensive health coverage for children, but eligibility for the program is based on family size and household income.
Creditable Coverage Disclosure Notice / Medicare Enrollees

Importance Notice
CREDITABLE COVERAGE DISCLOSURE NOTICE FOR ACTIVE EMPLOYEES AND/OR THEIR DEPENDENTS
Please read this notice carefully and keep it for your records.

Under the Medicare Modernization Act of 2003, a new Medicare-Approved Drug Plan (Part D) took effect as of January 1, 2006. This is your notice of creditable coverage.

• Your prescription drug coverage offered by Cigna Healthcare Plans, is, on average, as good or better as the standard Medicare prescription drug coverage.

• If you select one of the Cigna Healthcare Plans, you will not be penalized by Medicare if you decline to enroll in Medicare Part D at this time and decide to enroll in it at a later date. You will not have to pay the increased premium of at least one percent for each month that you did not elect to enroll in this plan after December 31, 2013 for an effective date of January 1, 2015.

• Creditable coverage means that the prescription drug coverage offered to you by the healthcare plan is, on average, as good as Medicare Part D coverage.

Medicare enrollment in the Medicare Part D Prescription Drug Plan was from November 2014, through December 2014.

For more information refer to your “Medicare & You 2015” handbook provided to you by Medicare, or by logging into www.medicare.gov or calling 1.800.MEDICARE (1.500.633.4227). TTY users should call 1.877.486.2048.

When To Enroll In Medicare Parts A & B
You should enroll 60 days prior to turning 65. If not, you may experience a lapse in your coverage.

Enrollment in Medicare While Actively Working
Active Employees Eligible for Medicare Parts A & B:

• If you and/or your covered dependent(s) are eligible for Medicare Parts A & B, you are provided the opportunity of enrolling in Medicare during the Special Enrollment Period.

• You do not need to enroll in Medicare while working and covered by a group healthcare plan through your employer. Please refer to your 2015 Medicare & You Book or by logging onto www.medicare.gov.

• However, if you do enroll in both Medicare Parts A&B, you can opt out of the School Board-sponsored healthcare plan (Cigna). In lieu of healthcare coverage, you will receive a monthly contribution of $100 paid through the payroll system based on your deduction schedule (subject to withholding and FICA). For additional information on how to enroll in healthcare, call the FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748).
Social Security Notice

THE SCHOOL BOARD OF MIAMI-DADE COUNTY

Statement on the Collection, Use or Release of Social Security Numbers of Employees and Others***

The School Board of Miami-Dade County is authorized to collect, use or release social security numbers (SSN) of employees, employee dependents, and other individuals*** for the following purposes, which are noted as either required or authorized by law to be collected. The collection of social security numbers is either specifically authorized by law or imperative for the performance of the District’s duties and responsibilities as prescribed by law [Fla. Stat. §§119.071(5)(a) 2 & 3].


2. Receipts to employees for wages and Statements required in case of sick pay paid by third parties [Required by federal statute 26 U.S.C. 6051 and Fla. Stat. § 119.071(5) (a) 6]

3. Verification of an alien’s eligibility for employment, including I-9 [Authorized by 8 U.S.C. 1324a(b) and 8 C.F.R. 274a.2]


5. Teacher retirement system benefits and contributions [Authorized by Fla. Stat. § 238.01 et seq., including 238.07, and Fla. Stat. § 119.071(5)(a) 6]


7. Teacher retirement system benefits and contributions [Required by 26 C.F.R. 301.6057-1 and Fla. Stat. §119.071(5)(a) 6]


9. Educator Certification or licensure application, renewal, or add-on, or non-employee registration for professional development for in-service points or incentive pay [Required by Fla. Stat. §§ 1012.56, and 119.071(5) (a) 6, and/or authorized by Fla. Stat. §§ 1012.21 and 119.071(5) (a) 6]

10. Criminal history, Level 1 and level 2 background checks / Identifiers for processing fingerprints by Department of Law Enforcement, if SSN is available [Required by Fla. Admin. Code 11C-6.003 and Fla. Stat. § 119.071(5)(a) 6]


12. Reports on staff required to be submitted to Florida Department of Education (DOE), including but not limited to Out-of-County/Out-of-State Verification of Highly Qualified [Authorized and required by Fla. Stat. § 119.071(5) (a) 2 & 6 and/or EDGAR at 34 CFR 80.40(a) or Fla. Stat. § 1008.32]


14. State directory of new hires (including for determining support obligations and eligibility for several federal and state programs) [Required by federal law 42 U.S.C. 653a and Fla. Stat. § 409.2576 and Fla. Stat. § 119.071(5)(a)]

15. Notice to Payor and Income Deduction notices for child support, or for alimony and child support [Required by Fla. Stat. § 61.1301 (2)(e) and Fla. Stat. § 119.071(5)(a)]

16. Child support enforcement [Required by 45 C.F.R. 307.11 and Fla. Stat. § 61.13, 742.10 or 409.256.3 or 742.031]

17. Garnishment payment pursuant to a Notice of Levy [Required by Fla. Admin. Code 12E-1.028m and Fla. Stat. § 119.071(5) (a)]

18. Request from depository for support payments [Required by Fla. Stat. § 61.181 (3)(b) and Fla. Stat. § 119.071(5)(a)]


22. Income information disclosure to HUD [Required by federal regulation 24 C.F.R. 5.214 et seq. and Fla. Stat. § 119.071(5)(a) 6]
23. Vendors/Consultants that District reasonably believes would receive a 1099 form if a tax identification number is not provided including for IRS form W-9. [Required by 26 C.F.R. § 31.3406-0, 26 C.F.R. § 301.6109-1, and Fla. Stat. § 119.071(5) (a) 2 & 6]

24. Tort claims and tort notices of claim against the School Board [Required by Fla. Stat. § 768.28 (6), and Fla. Stat. § 119.071(5) (a) 6]

25. Reporting to and reports of worker’s compensation injury or death, including for DWC-1 [Required by Fla. Stat. §440.185 and Fla. Admin. Code 69L-3.003 et seq. and Fla. Stat. § 119.071(S) (a) 6]

26. Worker’s compensation petitions for benefits and responses thereto [Authorized by Fla. Admin. Code 60Q-6.103 and Fla. Stat. § 119.071(S) (a) 6]

27. The disclosure of the social security number is for the purpose of the administration of retirement or health benefits for a District employee or his or her dependents [Required by Fla. Stat. § 119.071(S)(a) 6]

28. The disclosure of the social security number is for the purpose of the administration of a pension fund administered for the District employee’s retirement fund, deferred compensation plan, or defined contribution plan [Required by Fla. Stat. § 119.071(S)(a) 6]

29. Use of motor vehicle information from the Department of Motor Vehicles for the District to carry out its functions and to verify the accuracy of information submitted by agent or employee to District, including to prevent fraud, in connection with insurance investigations, and to verify a commercial driver’s license [Authorized allowed by federal law 18 U.S.C. 2721 et seq. and Fla. Stat. § 119.071(S) (a) 6]

30. Authorization for direct deposit of funds by electronic or other medium to a payee’s account [Required by Fla. Admin. Code 6A-1.0012 and Fla. Stat. § 119.071(S) (a) 6]

31. Identification of blood donors [Authorized by 42 U.S.C. 405 (c)(2)(D)(i)]

32. Employee’s and former employee’s request for report of exposure to radiation [Authorized by 41 C.F.R. 50-204.33 and .3]

33. Collection and/ or disclosure are imperative or necessary for the performance of the District’s duties and responsibilities as prescribed by law, including but not limited for password identification to the District’s network [Authorized by Fla. Stat. § 119.071(S)(a) 6 and required by Fla. Stat. § 119.071(S)(a) 2]

34. The disclosure of the social security number is expressly required by federal or state law or a court order [Required by Fla. Stat. §§ 1012.56 and 119.071(S) (a) 6]

35. The individual expressly consents in writing to the disclosure of his or her social security number [Allowed by Fla. Stat. § 119.071(S)(a) 6]

36. The disclosure of the social security number is made to prevent and combat terrorism to comply with the USA Patriot Act of 2001, Pub. L. No. 107-56, or Presidential Executive Order 13224 [Required by Fla. Stat. § 119.071(S)(a) 6]

37. The disclosure of the social security number is made to a commercial entity for the permissible uses set forth in the federal Driver’s Privacy Protection Act of 1994, 18 U.S.C. Sec. 2721 et seq.; the Fair Credit Reporting Act, 15 U.S.C. Sec. 1681 et seq.; or the Financial Services Modernization Act of 1999, 15 U.S.C. Sec. 6801 et seq., provided that the authorized commercial entity complies with the requirements of paragraph 5 in Fla. Stat. § 119.071 [Allowed by Fla. Stat. § 119.071(S)(a)6]

38. The disclosure of the social security number is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State [Required by Fla. Stat. § 119.071(S)(a)6]

***Note, this form states the reasons for collecting, using or releasing the social security numbers only of employees and individuals other than students, parents and volunteers. A separate written statement sets forth the reasons for collecting, using or releasing the social security numbers of students and parents, and a separate written statement exists for collecting, using or releasing the social security numbers of volunteers as part of the volunteer application.

School Board Attorney’s Office
New: October 1, 2009
Revised: April 12, 2010
# Full-Time Employee Healthcare Rates

## Medical Premiums - Employee Cost Share, Effective January 1, 2015 - December 31, 2015

### FULL TIME - SALARY ≤ $25K

<table>
<thead>
<tr>
<th>Plan</th>
<th>10-month (20 Deductions)</th>
<th>11-month (24 Deductions)</th>
<th>12-month (26 Deductions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cigna - OAP10</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$70.80</td>
<td>$59.00</td>
<td>$54.46</td>
</tr>
<tr>
<td>Spouse</td>
<td>$135.00</td>
<td>$112.50</td>
<td>$103.85</td>
</tr>
<tr>
<td>Children</td>
<td>$96.60</td>
<td>$80.50</td>
<td>$74.31</td>
</tr>
<tr>
<td>Family</td>
<td>$264.60</td>
<td>$220.50</td>
<td>$203.54</td>
</tr>
<tr>
<td>Employee &amp; Domestic Partner with Children</td>
<td>$264.60</td>
<td>$220.50</td>
<td>$203.54</td>
</tr>
<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$264.60</td>
<td>$220.50</td>
<td>$203.54</td>
</tr>
<tr>
<td><strong>Cigna - OAP20</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$6.00</td>
<td>$5.00</td>
<td>$4.62</td>
</tr>
<tr>
<td>Spouse/Domestic Partner</td>
<td>$99.00</td>
<td>$82.50</td>
<td>$76.15</td>
</tr>
<tr>
<td>Children</td>
<td>$69.60</td>
<td>$58.00</td>
<td>$53.54</td>
</tr>
<tr>
<td>Family</td>
<td>$194.40</td>
<td>$162.00</td>
<td>$149.54</td>
</tr>
<tr>
<td>Employee &amp; Domestic Partner with Children</td>
<td>$194.40</td>
<td>$162.00</td>
<td>$149.54</td>
</tr>
<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$194.40</td>
<td>$162.00</td>
<td>$149.54</td>
</tr>
<tr>
<td><strong>LocalPlus</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$96.60</td>
<td>$80.50</td>
<td>$74.31</td>
</tr>
<tr>
<td>Children</td>
<td>$69.00</td>
<td>$57.50</td>
<td>$53.08</td>
</tr>
<tr>
<td>Family</td>
<td>$183.60</td>
<td>$153.00</td>
<td>$141.23</td>
</tr>
<tr>
<td>Employee &amp; Domestic Partner with Children</td>
<td>$183.60</td>
<td>$153.00</td>
<td>$141.23</td>
</tr>
<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$183.60</td>
<td>$153.00</td>
<td>$141.23</td>
</tr>
</tbody>
</table>

* Employee-Only Rate must be added to the dependent rate, i.e., spouse/domestic partner, child(ren), or family to get the total deduction per paycheck.

### FULL TIME - SALARY > $25K - 40K

<table>
<thead>
<tr>
<th>Plan</th>
<th>10-month (20 Deductions)</th>
<th>11-month (24 Deductions)</th>
<th>12-month (26 Deductions)</th>
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<tbody>
<tr>
<td><strong>Cigna - OAP10</strong></td>
<td></td>
<td></td>
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<tr>
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<td>$70.62</td>
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<td>Spouse/Domestic Partner</td>
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<td>$144.46</td>
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<td>$102.92</td>
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<td>Family</td>
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<td>Employee &amp; Domestic Partner with Children</td>
<td>$363.00</td>
<td>$302.50</td>
<td>$279.23</td>
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<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$363.00</td>
<td>$302.50</td>
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<td><strong>Cigna - OAP20</strong></td>
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<td>$116.31</td>
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<td>$111.00</td>
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<td>Employee with Children &amp; Domestic Partner</td>
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<tr>
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<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$259.80</td>
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<td>$199.85</td>
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* Employee-only Rate must be added to the dependent rate, i.e., spouse/domestic partner, child(ren), or family to get the total deduction per paycheck.
# Full-Time Employee Healthcare Rates

**Medical Premiums - Employee Cost Share, Effective January 1, 2015 - December 31, 2015**

<table>
<thead>
<tr>
<th>FULL TIME - SALARY &gt; 40K - 55K</th>
<th>10-month (20 Deductions)</th>
<th>11-month (24 Deductions)</th>
<th>12-month (26 Deductions)</th>
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<tbody>
<tr>
<td><strong>Cigna - OAP10</strong></td>
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<tr>
<td>Employee</td>
<td>$104.40</td>
<td>$87.00</td>
<td>$80.31</td>
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<tr>
<td>Spouse/Domestic Partner</td>
<td>$301.80</td>
<td>$251.50</td>
<td>$232.15</td>
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<tr>
<td>Children</td>
<td>$226.80</td>
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<tr>
<td>Family</td>
<td>$523.80</td>
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<td>Employee &amp; Domestic Partner with Children</td>
<td>$523.80</td>
<td>$436.50</td>
<td>$402.92</td>
</tr>
<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$523.80</td>
<td>$436.50</td>
<td>$402.92</td>
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<tr>
<td><strong>Cigna - OAP20</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$18.00</td>
<td>$13.00</td>
<td>$13.85</td>
</tr>
<tr>
<td>Spouse/Domestic Partner</td>
<td>$247.80</td>
<td>$206.50</td>
<td>$190.62</td>
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<tr>
<td>Children</td>
<td>$189.60</td>
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<td>Family</td>
<td>$416.40</td>
<td>$347.00</td>
<td>$320.31</td>
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<tr>
<td>Employee &amp; Domestic Partner with Children</td>
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<td>$347.00</td>
<td>$320.31</td>
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<tr>
<td>Employee with Children &amp; Domestic Partner</td>
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<tr>
<td>Employee</td>
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<td>$0.00</td>
<td>$0.00</td>
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<td>Spouse/Domestic Partner</td>
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<td>$282.46</td>
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<tr>
<td>Employee &amp; Domestic Partner with Children</td>
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<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$367.20</td>
<td>$306.00</td>
<td>$282.46</td>
</tr>
</tbody>
</table>

*Employee-Only Rate must be added to the dependent rate, i.e., spouse/domestic partner, children, or family to get the total deduction per paycheck.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cigna - OAP10</strong></td>
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<tr>
<td>Employee</td>
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<td>$90.00</td>
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<td>Family</td>
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<td>$512.50</td>
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<td>$512.50</td>
<td>$473.08</td>
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<tr>
<td>Employee with Children &amp; Domestic Partner</td>
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<td>$512.50</td>
<td>$473.08</td>
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<td>Employee</td>
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<td>$20.00</td>
<td>$18.46</td>
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<td>Spouse/Domestic Partner</td>
<td>$295.20</td>
<td>$246.00</td>
<td>$227.08</td>
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<tr>
<td>Children</td>
<td>$226.80</td>
<td>$189.00</td>
<td>$174.46</td>
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<tr>
<td>Family</td>
<td>$493.80</td>
<td>$415.50</td>
<td>$379.85</td>
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<tr>
<td>Employee &amp; Domestic Partner with Children</td>
<td>$493.80</td>
<td>$415.50</td>
<td>$379.85</td>
</tr>
<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$493.80</td>
<td>$415.50</td>
<td>$379.85</td>
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<tr>
<td><strong>LocalPlus</strong></td>
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<tr>
<td>Employee</td>
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<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>Spouse/Domestic Partner</td>
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<td>$216.50</td>
<td>$199.85</td>
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<td>$204.60</td>
<td>$170.50</td>
<td>$157.38</td>
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<td>$351.50</td>
<td>$324.46</td>
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<tr>
<td>Employee &amp; Domestic Partner with Children</td>
<td>$421.80</td>
<td>$351.50</td>
<td>$324.46</td>
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<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$421.80</td>
<td>$351.50</td>
<td>$324.46</td>
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</table>

*Employee-Only Rate must be added to the dependent rate, i.e., spouse/domestic partner, children, or family to get the total deduction per paycheck.
### Full-Time Employee Healthcare Rates

**Medical Premiums - Employee Cost Share, Effective January 1, 2015 - December 31, 2015**

<table>
<thead>
<tr>
<th>FULL TIME - SALARY &gt;85K</th>
<th>10-month (20 Deductions)</th>
<th>11-month (24 Deductions)</th>
<th>12-month (26 Deductions)</th>
</tr>
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<tr>
<td><strong>Cigna - OAP10</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Employee</td>
<td>$130.20</td>
<td>$108.50</td>
<td>$100.15</td>
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<td>Spouse/Domestic Partner</td>
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<td>$712.80</td>
<td>$594.00</td>
<td>$548.31</td>
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<tr>
<td>Employee &amp; Domestic Partner with Children</td>
<td>$712.80</td>
<td>$594.00</td>
<td>$548.31</td>
</tr>
<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$712.80</td>
<td>$594.00</td>
<td>$548.31</td>
</tr>
<tr>
<td><strong>Cigna - OAP20</strong></td>
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<td></td>
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<tr>
<td>Employee</td>
<td>$42.00</td>
<td>$35.00</td>
<td>$32.31</td>
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<td>Spouse/Domestic Partner</td>
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<td>Children</td>
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<td>$196.15</td>
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<td>Family</td>
<td>$562.80</td>
<td>$469.00</td>
<td>$432.92</td>
</tr>
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<td>Employee &amp; Domestic Partner with Children</td>
<td>$562.80</td>
<td>$469.00</td>
<td>$432.92</td>
</tr>
<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$562.80</td>
<td>$469.00</td>
<td>$432.92</td>
</tr>
<tr>
<td><strong>LocalPlus</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
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<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Spouse/Domestic Partner</td>
<td>$295.20</td>
<td>$246.00</td>
<td>$227.08</td>
</tr>
<tr>
<td>Children</td>
<td>$233.40</td>
<td>$194.50</td>
<td>$179.54</td>
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<tr>
<td>Family</td>
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<td>$396.00</td>
<td>$365.54</td>
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<tr>
<td>Employee &amp; Domestic Partner with Children</td>
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<td>$396.00</td>
<td>$365.54</td>
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<tr>
<td>Employee with Children &amp; Domestic Partner</td>
<td>$475.20</td>
<td>$396.00</td>
<td>$365.54</td>
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* Employee-only Rate must be added to the dependent rate, i.e., spouse/domestic partner, children, or family to get the total deduction per paycheck.
# Part-Time (B,E,F,L) Employee Healthcare Rates


<table>
<thead>
<tr>
<th>CIGNA HEALTHCARE PLAN MONTHLY RATES</th>
<th>EMPLOYEE ONLY</th>
<th>EE + CHILD(REN)</th>
<th>EE + SPOUSE/DOMESTIC PARTNER</th>
<th>EE + FAMILY</th>
<th>ADULT CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigna OAP 10</td>
<td>$692.00</td>
<td>$1,379.00</td>
<td>$1,669.00</td>
<td>$2,648.00</td>
<td>$588.00 per child</td>
</tr>
<tr>
<td>Cigna OAP 20</td>
<td>$656.00</td>
<td>$1,310.00</td>
<td>$1,585.00</td>
<td>$2,514.00</td>
<td>$537.00 per child</td>
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<td>$1,308.00</td>
<td>$1,585.00</td>
<td>$2,510.00</td>
<td>$541.00 per child</td>
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**Part-Time Food Service Employee Healthcare Rates**

**Medical Premiums - Employee Cost Share, Effective January 1, 2015 - December 31, 2015**

<table>
<thead>
<tr>
<th>Cigna OAP 20 Healthcare Rates</th>
<th>10-month (20 Deductions)</th>
<th>11-month (24 Deductions)</th>
<th>12-month (26 Deductions)</th>
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<tbody>
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<td>Employee</td>
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<td>$455.94</td>
<td>$379.95</td>
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<td>$301.92</td>
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<td>Family</td>
<td>$944.06</td>
<td>$786.72</td>
<td>$726.20</td>
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<table>
<thead>
<tr>
<th>Cigna LocalPlus Healthcare Rates</th>
<th>10-month (20 Deductions)</th>
<th>11-month (24 Deductions)</th>
<th>12-month (26 Deductions)</th>
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<tbody>
<tr>
<td>Employee</td>
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<td>$0</td>
<td>$0</td>
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<td>Spouse/Domestic Partner</td>
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<td>Family</td>
<td>$942.54</td>
<td>$785.45</td>
<td>$725.03</td>
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## COBRA Participant Healthcare Rates

### Monthly Healthcare Rates: Effective January 1, 2015 - December 31, 2015

<table>
<thead>
<tr>
<th>CIGNA MEDICAL</th>
<th>OAP 10</th>
<th>OAP 20</th>
<th>LocalPlus</th>
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<tr>
<td>Participant Only</td>
<td>$705.84</td>
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<td>$668.10</td>
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<tr>
<td>Participant &amp; Spouse</td>
<td>$1,702.38</td>
<td>$1,616.70</td>
<td>$1,614.66</td>
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<tr>
<td>Participant &amp; Child(ren)</td>
<td>$1,406.58</td>
<td>$1,336.20</td>
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<tr>
<td>Participant &amp; Family</td>
<td>$2,700.96</td>
<td>$2,564.28</td>
<td>$2,560.10</td>
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<tr>
<td>Participant &amp; Adult Child</td>
<td>$1,305.60</td>
<td>$1,216.86</td>
<td>$1,219.92</td>
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</tbody>
</table>
Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.