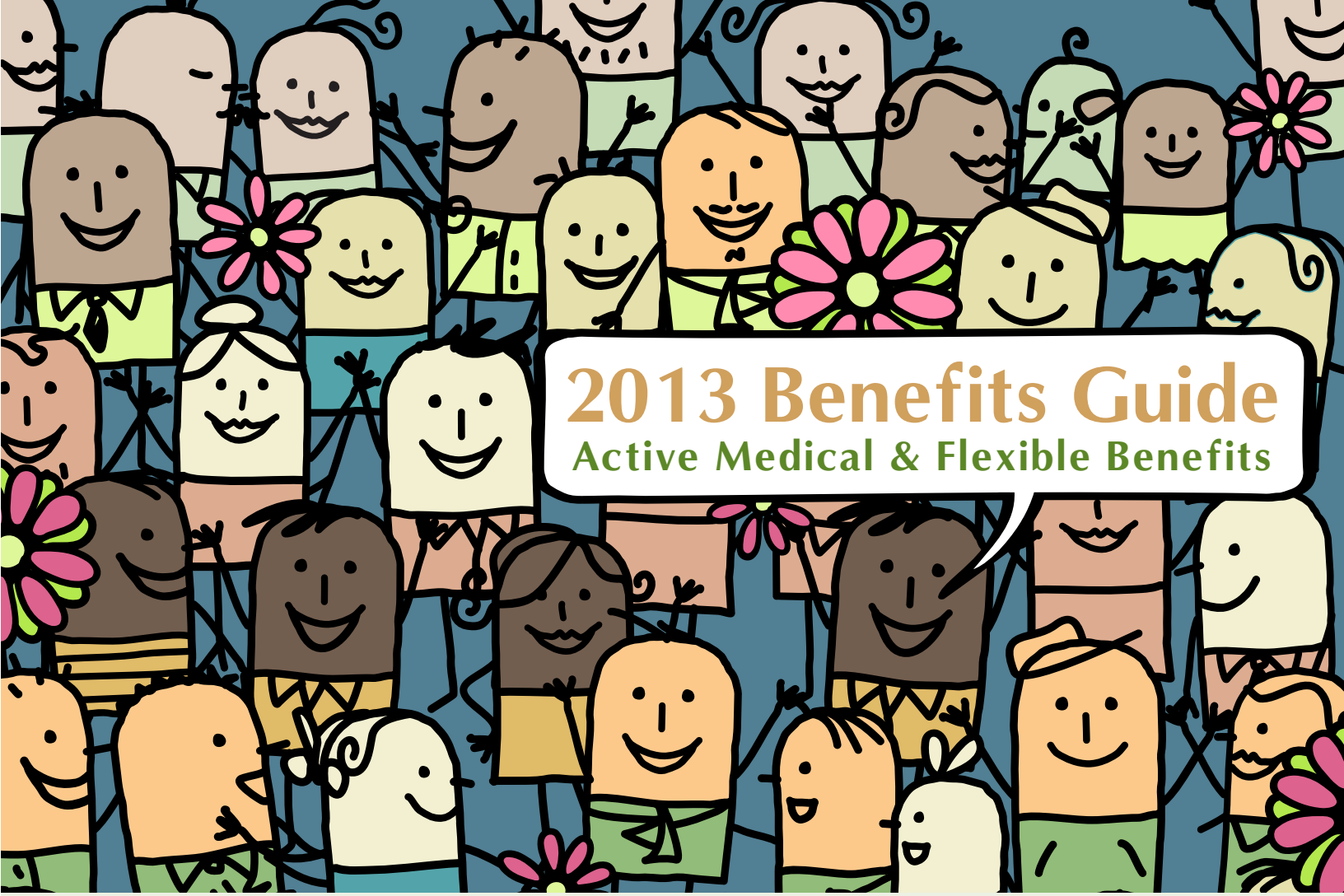
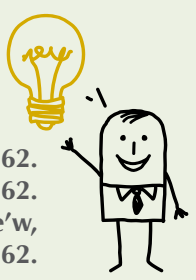


2013 Benefits Guide

Active Medical & Flexible Benefits

We've Got you COVERED

M-DCPS



For assistance in English, please call 1.855.569.3262.
Para ayuda en Español, llame a 1.855.569.3262.
Si'w ta bezwen yon moun ki pale Kreyòl ki pou ede'w,
tanpri rele nan nimewo 1.855.569.3262.

Enrollment Time

This is a changes only enrollment. If you do not make any changes, your current benefits will continue and plan design changes and premiums will automatically be adjusted.

This Open Enrollment is for benefits effective January 1, 2013, through December 31, 2013.

It's Benefits Enrollment Time

Healthcare costs represent the second highest expenditure of funds for M-DCPS after payroll. While the cost of healthcare continues to skyrocket, the diligent efforts of the Superintendent of Schools and School Board members – in conjunction with employees, unions and associations – have resulted in a plan with rich benefits, an employer-paid, employee-only option (FOP Bargaining still pending), low dependent costs and direct access to specialists.

This is a changes only enrollment. If you do not enroll during the open enrollment period, your current benefits and those of your dependents will continue. Both plan design changes and premiums will automatically be adjusted. All employees must view their benefits statement via the Internet.

The premiums and benefits selected during the enrollment period of December 3, 2012 through December 14, 2012 are for an effective date of January 1, 2013. You must enroll during this open enrollment period if you would like to make changes to your healthcare and/or flexible benefits (i.e., Dental, Vision, etc.) or to add, delete or continue covering your dependents.

NOTE: During this enrollment, all employees are eligible to enroll at this time, except FOP.

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

New Employee: A new employee is defined as an employee without active benefits. If you are a new employee hired during this open enrollment period, you must enroll for both plan years. You will receive an e-mail prompting you to enroll online for your benefits. You must enroll online by the due date. Otherwise, you will be automatically assigned to Cigna Open Access Plus 20 (employee-only) coverage and the Standard Short-Term Disability plan.

All employees must view their 2013 benefits statement via the Internet. To make changes to your current benefits and view your benefits statement, log on to **www.dadeschools.net.**

- Log onto the Employee Portal
- Enter your login username and password
- Check on the "2013 Open Enrollment" link.

Opting Out Of Healthcare

- You may decline Board-Paid healthcare coverage, provided you are enrolled in another group healthcare plan or state-funded program.
- After your enrollment, you will be asked to submit your proof of other coverage.

Dependent Coverage:

- This year, you are required to submit dependent documentation for all the dependent(s) you are covering. Documentation can be mailed or faxed to the Office of Risk and Benefits Management before December 21, 2012. Please refer to Page 26, for further details and mailing information.
- If you are adding new dependents, you will need to enter their Social Security numbers on the web enrollment application and you will need to submit dependent eligibility verification before the start of this plan year. If not, your dependent's coverage may NOT take effect on January 1, 2013.
- An employee's dependent may be covered under the employee's healthcare plan until the end of the calendar year they reach 26.
- To enroll an adult child dependent (ages 26-30), you must enroll and submit dependent eligibility documentation with your enrollment form each year. If dependent eligibility is not received, your adult child will automatically be cancelled January 1, 2013.
- In compliance with the Patient Protection and Affordable Care Act (PPACA Healthcare Reform), effective January 1, 2013, the maximum annual contribution for a Medical Expense Flexible Spending Account (FSA) will be $2,500 individual maximum and $5,000, combined for employee and spouse.

Benefits Update

- If you choose to opt-out of healthcare coverage, and do not provide proof of other group or state-funded healthcare coverage, you will be automatically assigned the Cigna Open Access Plus 20 (employee-only) healthcare plan and your dependents will not be covered.
- In lieu of Board-Paid healthcare coverage, you will receive $100 per month, paid bi-weekly, through the payroll system, based on your deduction pay schedule (subject to withholding and FICA), as follows:
  - 10-month employees will receive their payment in 20 pay checks.
  - 11-month employees will receive their payment in 24 pay checks.
  - 12-month employees will receive their payment in 26 pay checks.

Core Benefits

- The Board provides two healthcare plans: Cigna OAP 20 and Cigna OAP 10. OAP 20 is at no cost to the employee. OAP 10 has an employee cost share, determined by the employee's base salary. Please refer to Page 156 for the employee cost share and your dependent cost. (AFSCME employees are only eligible to enroll in OAP 20).
- All employees enrolling during the open enrollment of December 3, 2012 through December 14, 2012 in the OAP 10 will have the cost share deducted from the first 2013 Plan Year payroll, on January 11, 2013.
- New-hire employees hired after January 1, 2013 will continue to have their healthcare coverage effective the day of hire and will start paying for the cost share (only if enrolling in OAP 10) on the first paycheck following the effective date of their healthcare coverage.
- The Board will continue to pay a portion of your dependent's healthcare coverage. The subsidy paid by the School Board is, in some cases, up to 83 percent of the premium.
- You are provided with Board-Paid, Standard Short-Term Disability (STD) coverage.
- The School Board provides a Term Life and Accidental Death and Dismemberment (AD&D) program with Metropolitan Life Insurance Company for all full-time employees. The coverage amount is either one or two times your annual base salary, rounded up to the next $1,000. Administrators and Confidential Exempt employees receive two times the annual base salary. All other employees receive one times their annual base salary. The minimum benefit for employees represented by AFSCME is $10,000. Additional life insurance may be purchased through payroll deduction to bring maximum benefits to an additional, one times the amount provided by the School Board. You will be eligible to increase your coverage to a maximum of fives times the annual base salary after the first year of participation in the optional life program. Evidence of Insurability will be required for any increases in coverage. To find out more about Board-Paid Term Life and Accidental Death and Dismemberment, contact the MetLife Representative at 305.995.7029.

Healthcare Coverage

The School Board of Miami-Dade County, Florida, is committed to providing you and your eligible dependents with the highest quality of benefit selections available.

- **Cigna Open Access Plus (OAP) 10 –** Employees electing this plan will continue to pay a cost-share, based on their salary band.
- **Cigna Open Access Plus (OAP) 20 –** Remains a free-option, no-cost-for-employee-only coverage.

Plan design for both OAP 10 and OAP 20 changes are effective January 1, 2013.

- Convenience Care Centers co-pay is $10
- Increase deductible by $250 for employee
- Increase deductible by $500 for family
- Increase co-insurance by 10% (In and Out-of-network)
- Speech, occupational and physical therapy co-pays $50

- Primary Care Physician co-payment remains $25 per visit.
- Cigna Care Network (CCN) Specialist, a specialist designated network that has been identified by Cigna to have demonstrated the best in management of patient treatment.
- Cigna Care Network (CCN) Specialist co-pay at $50 per visit.
- Non CCN Specialist co-pay at $70 per visit.
- Urgent Care Centers - you pay a $70 co-pay
- Emergency Room - you pay a $300 co-pay, $150 at JMH Facilities
- The Open Access Plan does not require the selection of a Primary Care Physician or a referral to a specialist.
- Outpatient tests/surgeries at non-hospital-affiliated facilities remain at $100 per procedure.
- Deductible, maximum and/or out-of-pocket and co-insurance will continue to apply only to hospital and hospital-affiliated facilities.
- Mandatory Prescription Mail Order Program gives employees the ability to manage medications online 24/7, at www.mycigna.com. This program delivers prescribed medications to employee's home for up to a 90-day supply within a co-pay of two times the tier cost, saving time and money.
- Durable Medical Equipment (DME) will continue to be covered, a deductible and co-insurance applies. This benefit provides employees a richer benefit because once the maximum out-of-pocket has been met, the coverage will be 100 percent.

Dependent Coverage for 2013

- Premiums will continue to be based on the employee's annual base salary. M-DCPS will continue to subsidize the cost or dependent premium between 39-83 percent.
- Dependent Social Security numbers are required during open enrollment. If your dependent's Social Security number is not provided, coverage for the dependent cannot be processed via the online enrollment. For additional information, call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262).
- Documentation of your dependent's eligibility must be provided. Eligibility documentation requirements can be found on Pages 23-30.
- Children may include: natural-born children, stepchildren, adopted children and children for whom you have been appointed legal guardian. Your unmarried children are eligible from birth until the end of the year in which the child reaches age 26, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university. See also Adult Child on Page 29.
- Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is also included in the coverage.
- According to IRS (Internal Revenue Service) Section 125 Regulations, all deductions for employee-paid benefits for domestic partner

coverage must be taken on a post-tax basis. Additionally, you must pay the tax liability on the monthly contribution (subsidy) that the Board pays, on your behalf, for any type of Domestic Partner coverage. Therefore, the value of these benefits will be added to your taxable income and your W-2 will be adjusted to reflect the higher income level annually.

- Taxation for the monthly, board-paid dependent subsidy contributed on the employee's behalf for domestic partner coverage, will occur on the last pay statement of each month.
- Employee's covering their children and a domestic partner will only be taxed on the Board subsidy toward the domestic partner coverage. **NOTE**: Employees covering a domestic partner and children of the domestic partner will continue to be taxed on the full, Board-paid dependent subsidy. Employees covering their own children, a domestic partner and children of a domestic partner will also be taxed on the entire Board-paid dependent subsidy.

AFSCME - Flex Credit

Employees represented by the AFSCME Union and enrolled in Cigna OAP 20 will continue to receive a $280 annually flex credit. This flex credit can be used to offset the cost of your flexible benefits.

Flexible Benefits

- Short-Term Disability coverage continues to be provided at no cost to you. In addition, upgrades to the Short-Term Disability and Long-Term Disability are also being offered.
- Miami-Dade County Public Schools will continue to offer a broad range of high-quality, elective benefits at very competitive prices, including:
  - Dental provider, MetLife Dental, is offering MetLife SafeGuard DHMO, a comprehensive DHMO plan. You will need to choose your dental provider at the time you enroll. Your selected general dentist will refer you directly to a contracted specialty care provider. No additional referral or pre-authorization from SafeGuard, a MetLife Company, is required.
  - This plan offers you the option of selecting a dentist of your choice. You are free to choose an in-network or out-of-network dentist. However, when using an out-of-network dentist, the level of coverage is reduced and your out-of-pocket expenses will increase.
  - MetLife Indemnity Dental Plans continue to be offered.
  - Vision provider, UnitedHealthcare, offers access to both private practice and retail chain providers that provide quality eye care and materials.
  - Choose from two legal plans: The ARAG Group Legal Plan and the US Legal Plan.
  - Identity Theft Protection, ID Watchdog, offers identity theft protection by verification of your identity, monitoring, detection and resolution of fraud.
  - Hospital Indemnity coverage
  - Short-Term Disability upgrades
  - Long-Term Disability
  - MetLife Term Voluntary Life insurance
  - MetLife Accidental Death and Dismemberment coverage
  - **Flexible Spending Accounts - NOTE: Current FSA participants' accounts will not terminate, if you do not re-enroll. However, in compliance with Healthcare Reform, employees cannot contribute more than $2,500 annually to a Medical Expense FSA. For employees who contributed a greater amount in 2012 and are not re-enrolling, their contribution will automatically be changed to the minimum annual amount of $2,500.**
- Certain Over-the-Counter (OTC) drugs and medicines, except for diabetes supplies, requires a prescription to qualify for FSA reimbursement. It's important to remember that you can still use your FSA funds for other eligible medical expenses and prescription purchases at pharmacies. Unaffected OTC items are still reimbursable, as well as affected OTC items with a doctor's prescription.
- Effective January 1, 2013, the maximum annual contribution amount for a Medical Expense Flexible Spending Account (FSA) will be $2,500.

Evidence of Insurability (EOI)

If you are a current employee who chose not to enroll previously in Short-Term Disability buy up plans or the Long-Term Disability plan, **you must complete an Evidence of Insurability (EOI) form before you are considered for coverage.**

You must complete an EOI form which will be mailed and verified by The Hartford. If your buy up or LTD EOI is approved, the effective date of this benefit will be the first of the month following your first payroll deduction. New hires do not need to provide EOI.

NOTE: If enrolling in this benefit during this Open Enrollment period, your online Open Enrollment Confirmation Notice will reflect a $0.00 deduction for this benefit, which will change if your EOI is approved. The deduction will be taken on the last paycheck of the month after your approval, which makes your benefit effective the first of the following month after your first payroll deduction.

EOI forms will be mailed by The Hartford. For any questions, you may call a Hartford Representative at 305.95.4889 or 1.800.741.4306.

Throughout the Plan Year

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

Table of Contents

Important Phone Numbers and Hours of Operation

Enrollment Help Line
305.995.2777

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

Benefits Inquiry
FBMC Service Center
Mon - Fri, 7 a.m. - 8 p.m. ET
1.855.5MYFBMC (1.855.569.3262)

HEALTHCARE PROVIDER

Cigna
24-hours/7 days a week
1.800.806.3052
www.cigna.com

FLEXPLAN PROVIDERS

Dental Plans

SafeGuard MetLife DHMO Plans
Customer Service/Claims
Mon - Thur, 8 a.m. - 8 p.m. (All Zones)
Fri, 8 a.m. - 5 p.m. (All Zones)
1.800.880.1800
www.metlife.com/mybenefits

MetLife Indemnity Plans
Customer Service/Claims
Mon - Thur, 8 a.m. - 8 p.m. (All Zones)
Fri, 8 a.m. - 5 p.m. (All Zones)
1.800.942.0854
www.metlife.com/mybenefits

Vision Plan

UnitedHealthcare Vision
Customer Service
Mon - Fri, 8 a.m. - 11 p.m. ET
Sat 9 a.m. - 6:30 p.m. ET
1.800.638.3120

Legal Plans

ARAG® Legal Plan Customer Care
Mon - Fri, 8 a.m. - 8 p.m. ET
1.800.360.5567
ARAGLegalCenter.com,
Access Code: 10287mds
SeniorAdvocate™ Plan

ARAG
Mon - Fri, 8 a.m. - 8 p.m. ET
1.800.360.5567
ARAGLegalCenter.com,
Access Code: 10287mds

US Legal
Family Defender
Customer Service
1.800.356.LAWS
Available 24/7
http://home.uslegalservices.net/M-DCPS

Senior Defender
Customer Service
1.800.356.LAWS
Available 24/7
http://home.uslegalservices.net/M-DCPS

The Short-Term & Long-Term Disability Plans

Hartford Life and Accident Insurance Company
Customer Service 305.995.4889
To File a Claim 1.800.741.4306
Medical Underwriting 1.800.331.7234
www.thehartfordatwork.com

Identity Theft Plan

ID Watchdog, Inc.
Customer Service
1.800.970.5182
Mon - Fri, 8 a.m. - 6 p.m. (MST)
www.idwatchdog.com

Hospital Indemnity Coverage

Life Insurance Co. of North America
(A Cigna Company)
Customer Service/Claims
Mon - Fri, 7 a.m. - 8 p.m. ET
1.855.5MYFBMC (1.855.569.3262)

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

MetLife Voluntary Life Claims
Customer Service
305.995.7029
Mon - Fri, 8 a.m. - 8 p.m. ET
1.800.638.6420, option #2

Flexible Spending Accounts & myFBMC Card® Visa® Card

WageWorks
Service Center & myFBMC® Card Activation
1.855.5MYFBMC (1.855.569.3262)

Mon - Fri, 7 a.m. - 8 p.m. ET

Automated Services - 24/7
1.800.865.3262
Lost or Stolen myFBMC Card® - 24/7
1.888.462.1909

401(k)

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

OTHER IMPORTANT NUMBERS

For general benefit and enrollment information throughout the year

Miami-Dade County Public Schools
Office of Risk and Benefits Management
Automated Phone System
Mon - Fri, 8 a.m. - 4:30 p.m. ET
305.995.7129
305.995.7130
305.995.7190 FAX

Office of Retirement/Leave/Unemployment
305.995.7090

Payroll Deduction Control
Automated Phone System
Mon - Fri, 8 a.m. - 4:30 p.m. ET
305.995.1655
305.995.1644 (FAX)

Life Insurance

MetLife Group Life Claims
Customer Service
305.995.7029
Mon - Fri, 8 a.m. - 8 p.m. ET
1.800.638.6420, option #2

Florida KidCare
1.888.540.5437
www.floridacare.org

* Third Party Administrator for the M-DCPS Fringe Benefits Program.

Before You Enroll Online

Preparing to Enroll Online

These *How to Enroll Online* instructions serve as a quick reference to help you enroll in your 2013 Plan Year benefits through your employee portal. Before you begin your online enrollment, be sure to gather pertinent information in the checklist below.

Checklist to Enroll Online

- ✓ Your M-DCPS Portal Username and Password
- ✓ Dependents' Name
- ✓ Dependents' Date of Birth
- ✓ Dependents' Relationship
- ✓ Dependents' VALID Social Security Number
- ✓ You and your dependent's Primary Dental Provider (PDP), if selecting the Safeguard DHMO Standard or High Plan
- ✓ Beneficiaries' Percentage of Coverage
- ✓ Beneficiaries' Name **(or Will/Trust or Charity Organization Name)**
- ✓ Beneficiaries' Relationship
- ✓ Beneficiaries' VALID Social Security Number
- ✓ **If selecting a local Charity Organization, their address is required.**
- ✓ Disable the Pop-Up-Blocker on your computer to allow your Confirmation Notice to display at the end of your enrollment session.
- ✓ If electing to decline healthcare coverage, proof of other group or state-funded healthcare must be submitted to the Office of Risk and Benefits Management. Proof must include the effective date of group coverage. Otherwise, coverage will be terminated and the employee will automatically be assigned to Cigna OAP 20 employee-only coverage.
- ✓ Proof of dependent eligibility must be submitted to the Office of Risk and Benefits Management for all added dependent(s). Otherwise, coverage may be terminated for any dependent whose eligibility has not been verified, claims incurred will not be paid and any premiums deducted will not be automatically issued.

Benefits through the Employee Portal

www.dadeschools.net

Taxation of Board-Paid Benefits

Taxation of monthly, Board dependent subsidy toward any type of domestic partner coverage occurs every month on the last paycheck of the month.

Employees enrolled in either medical, dental or vision coverage for a domestic partner or domestic partner and family will have the deduction taken from the employee's paycheck as a post-tax deduction.

The cost of Board-paid Life Insurance in excess of $50,000 will be taxed on every paycheck.

The taxable benefits are:

1) The cost of life insurance premiums in excess of $50,000.00, which are paid/subsidized by the Board.
2) The monthly contribution (subsidy) that the Board pays on the employee's behalf for any type of Domestic Partner coverage and/or children of the domestic partner.

W-2 Reporting, Effective January 1, 2013

Effective January 1, 2013, the IRS requires employers to report the cost of their employee-sponsored healthcare coverage. Therefore, the Board's contribution toward both the employee's and dependent coverage will appear in your W-2.

NOTE: This reporting is only informational data. You are not being taxed on this amount.

Medical Opt Out

Employees who have declined to participate in the District's medical insurance plan (Medical Opt Out) will receive $100.00 per month, based on the employee's deduction schedule, as follows:

1) 10-month employees will receive their payment in 20 bi-weekly pay checks.
2) 11-month employees will receive their payment in 24 bi-weekly pay checks.
3) 12-month employees will receive their payment in 26 bi-weekly pay checks.

Employees Returning to Work After a Leave Status

Employees in a Board-approved leave of absence will be billed for employee-paid benefits in accordance to the type of leave. The benefits for which you have been billed will be cancelled, if payment is not received by the end of the grace period. If you return to work prior to receiving a Grace Period Notice, the premiums due will be automatically deducted from your bi-weekly check (one regular deduction plus one arrears) until the full amount of the outstanding premiums are paid in full.

Viewing your Benefits in SAP

Listed below are steps to view your benefits in the new SAP system:

1. Log on to www.dadeschools.net, then the employee portal

2. Click on the ERP Tab

3. Click on the Employee Self Service tab

4. Click the Benefits link

5. Then, click on Participation Overview

6. You may view benefits as of a specific period of time by clicking on the box "display your benefits as of." Please note, the benefits displayed will be per your last selection or, if not making changes, your current benefits that are rolling over with the 2013 rates.

Benefits through the Employee Portal

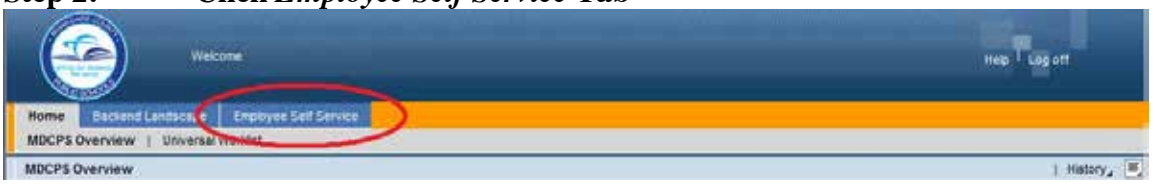
www.dadeschools.net

Steps to Update Beneficiaries

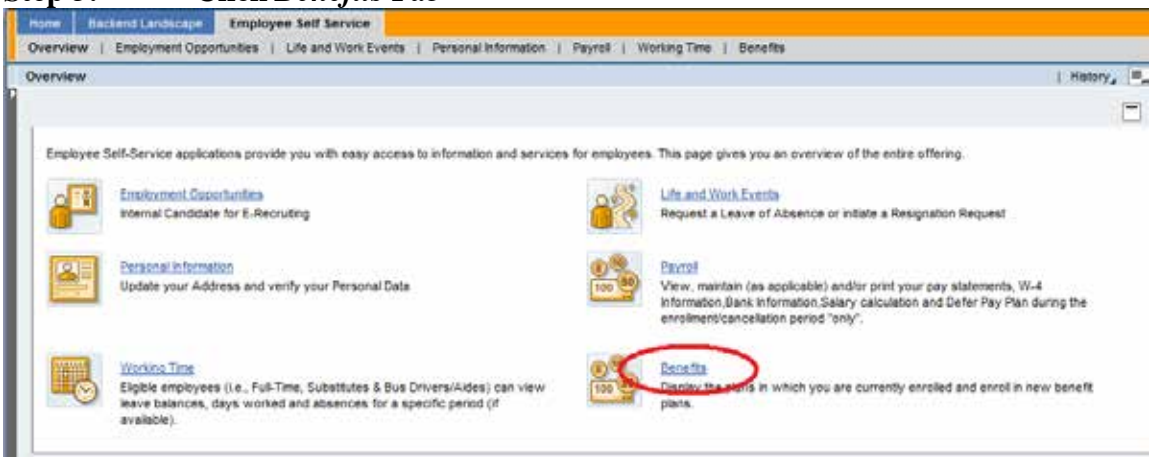
Login to Employee Portal

Step 1: **Click on *ERP* Tab**

Step 2: **Click *Employee Self Service* Tab**

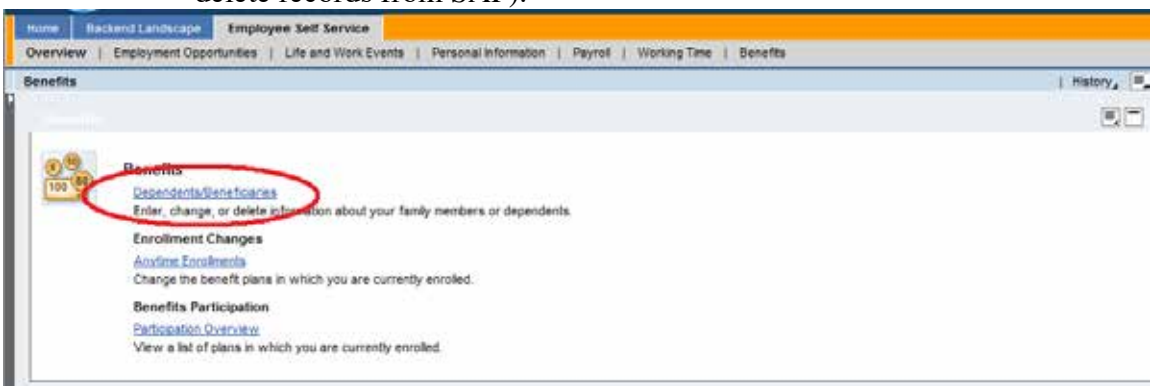


Step 3: **Click *Benefits Tab***



Step 4: **Click on *Dependents/Beneficiary***

To add or edit Dependents/Beneficiaries (please note that you are not able to delete records from SAP).



How to Enroll Online

www.dadeschools.net

Before You Start Your Web Enrollment

Prior to enrolling in your benefits online, it is to your advantage to thoroughly review this reference guide. If you are ready to enroll, but need assistance, contact the Enrollment Help Line at 305.995.2777 (to connect to the FBMC Service Center, call 1.855.569.3262). Once you have the answers you need, you may begin the enrollment process

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

Your benefit changes and new payroll deductions are effective January 1, 2013.

Regardless of whether you plan to change anything or not, please **review and print your 2013 Employee Benefits Statement.**

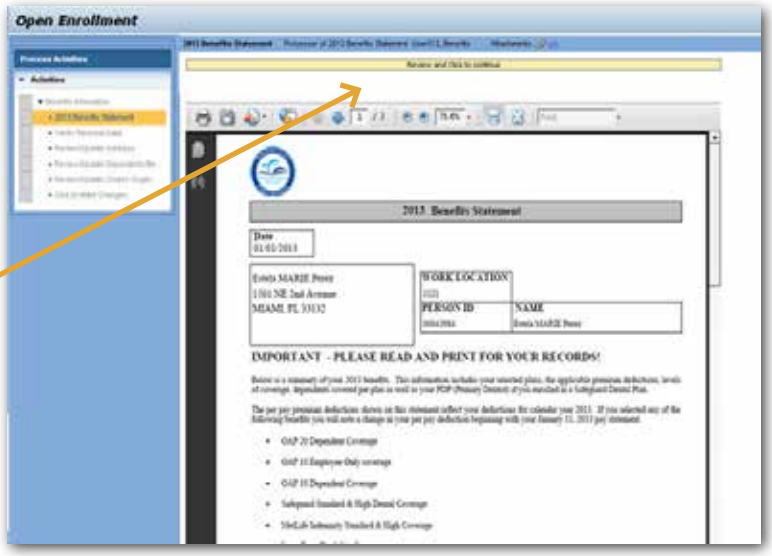
Click here to login and begin your enrollment

How to Enroll Online

www.dadeschools.net

REMINDER! Confirm your 2013 Benefits Statement first.

At the beginning of your enrollment session, you must review your 2013 Benefits Statement to confirm that your benefit selections are correct. Regardless of whether you are making benefit selection changes or keeping your current benefits, you must confirm your 2013 benefits statement.



If you do not make changes, you must click **Review and click to continue** to confirm your 2013 benefits statement, then exit the application. Your current benefits will automatically continue and any new per pay premium deductions will be taken for the 2013 Plan Year.

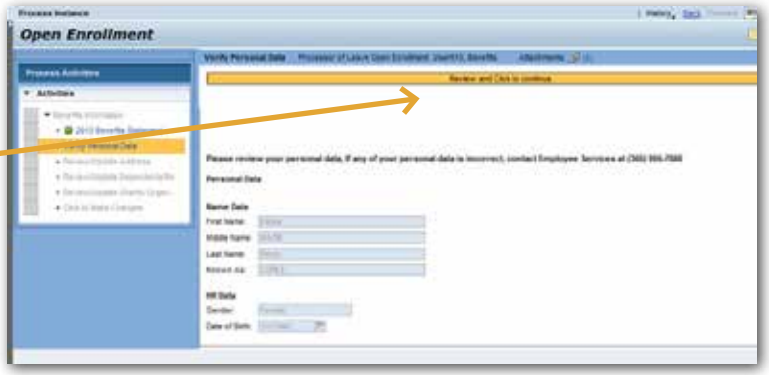
If you ARE making changes, you must click **Review and Click to continue** in order to begin making changes.

If no changes are needed, you may close the browser by **CLICKING** the **X** on the upper, right corner of the screen.

2 Review your personal data.

Please review your personal data. If any of your personal data is incorrect, contact Employee Services at 305.995.7888.

Click **Review and click to continue** to begin to make changes.



3 Update your address.

If you do NOT have changes, click **Review and click to continue** to the next step. After reviewing your changes to each section, ALWAYS click to save your entries.

If your address or phone number is not correct, use the **EDIT** button to make corrections. You may add an Emergency Contact person in this section.

How to Enroll Online

www.dadeschools.net

4 Update your dependent and/or beneficiary information.

If you DO NOT have changes, click **Review and click to continue** to the next step.

If you wish to select coverage for your dependents or list them as a beneficiary on any plan, you must add their information in this section. You may also correct the address for any dependent already listed. Adding a dependent or beneficiary in this section DOES NOT provide them insurance coverage or list them as your beneficiary. This is the list of people you will be able to select from during your enrollment session.

If you need to make any other type of correction, please contact The Office of Risk & Benefits Management at 305.995.7129.

5 Add or change your charity organization, will or trust.

If you DO NOT have changes, click **Review and click to continue** to the next step.

You may add or change a charity organization or add or change a will or trust designation by clicking on the appropriate box.

If you would like to select a trust, will or charity organization as a beneficiary during your Employee Benefits enrollment process, please add their information in this section.

You do not need to include an address when adding a **NATIONAL** charity or organization.

Review your selection carefully before you click **SAVE**.

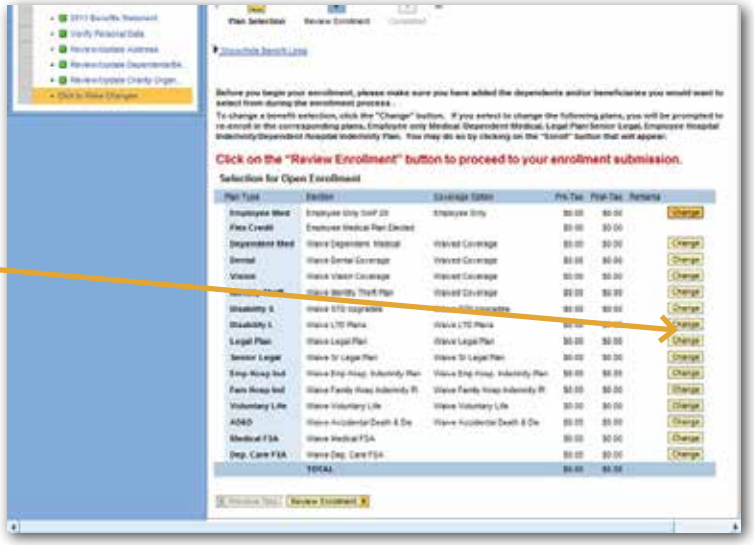
How to Enroll Online

www.dadeschools.net

6 Making Changes to Your Benefits Plan Coverage for 2013

You may select whichever plan type you wish to change. The highlighted selections that appear on the screen are your current 2012 plans with your 2013 per pay deductions.

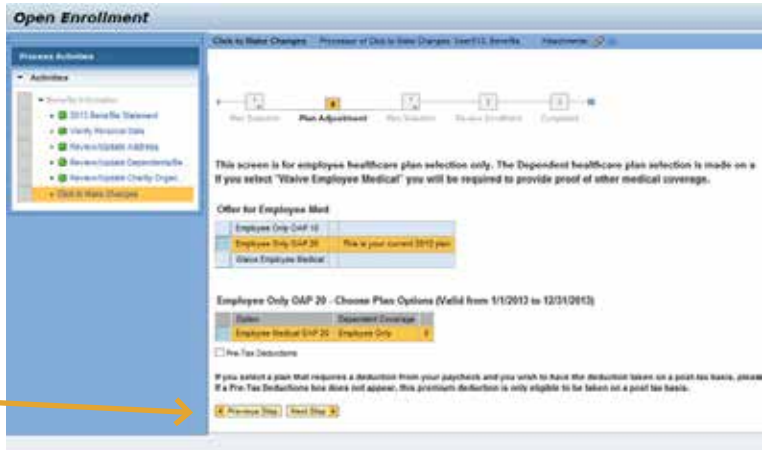
To change a benefit selection, click the **Change** button.



If you select to change the following plans, you will be prompted to re-enroll in the corresponding plans, Employee only Medical/ Dependent Medical, Legal Plan/Senior Legal, Employee Hospital Indemnity/Dependent Hospital Indemnity Plan.

If you wish to have your per pay deduction from your paycheck, on a post-tax basis. **Just unclick the X in the box** next to pre-tax deductions.

Click **Next Step to continue.**



How to Enroll Online

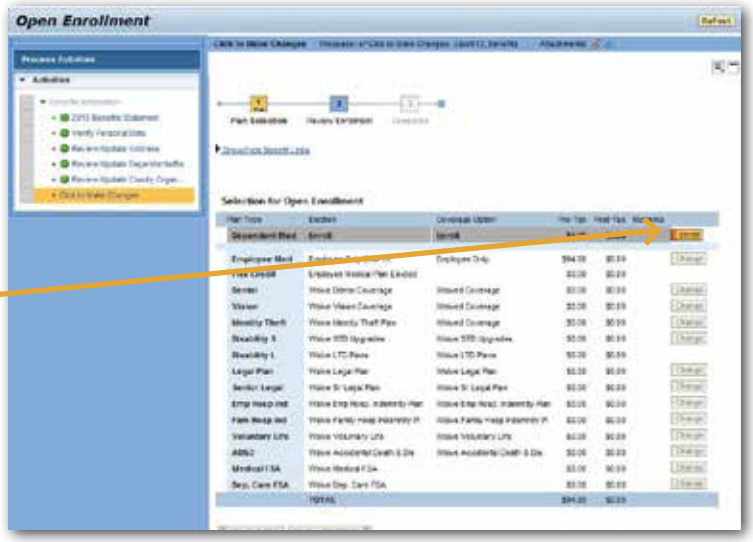
www.dadeschools.net

7 Enroll or Waive Your Dependent's Coverage

Be sure to review your dependent coverage selections carefully.

PLEASE NOTE: Your plan selection prompted you to take an additional step to verify whether you wish to change or continue with the same coverage for your dependents.

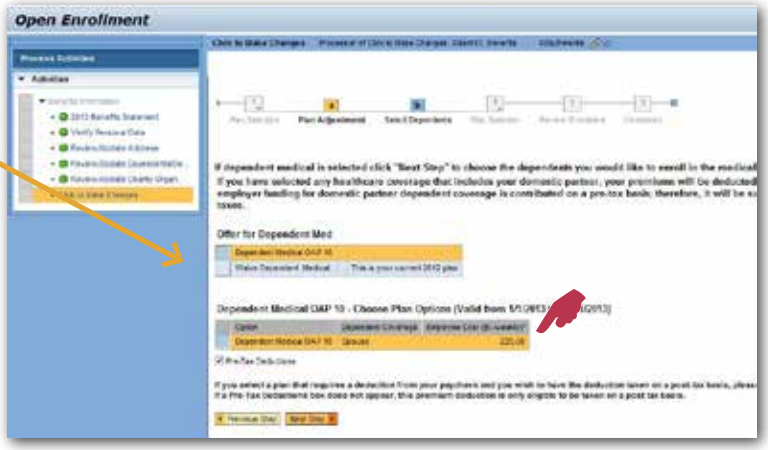
You must click on Enroll and save your decision.



If you do not wish to cover your dependent for the 2013 Plan Year, you must select to **WAIVE dependent coverage.**

The per pay deduction amount is listed.

Based on your dependent's benefits eligibility, different levels of dependent coverage will appear highlighted on the screen.



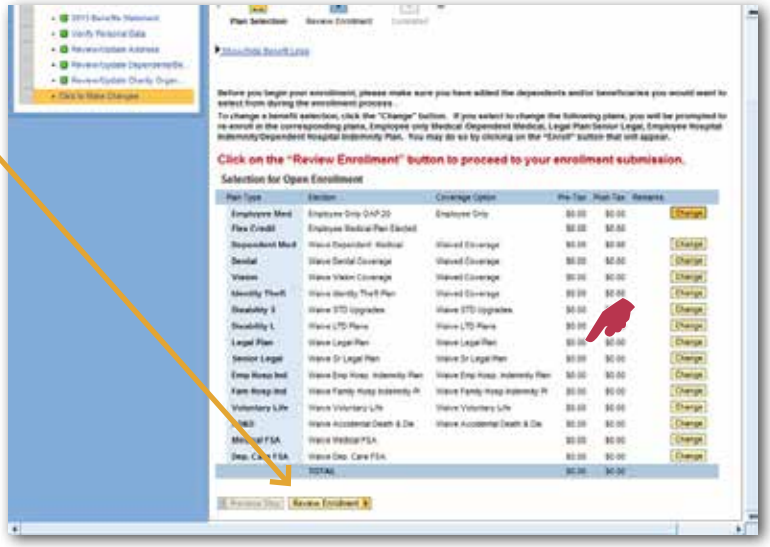
How to Enroll Online

www.dadeschools.net

8 Making Changes

Click on the **Review Enrollment** button to proceed to your enrollment submission where you can review your selections and make changes.

NOTE: The per pay deductions amount are included in this section.



9 Submit

Click on the **Submit** button to save your enrollment selections.

Review your selections **carefully** before submitting.

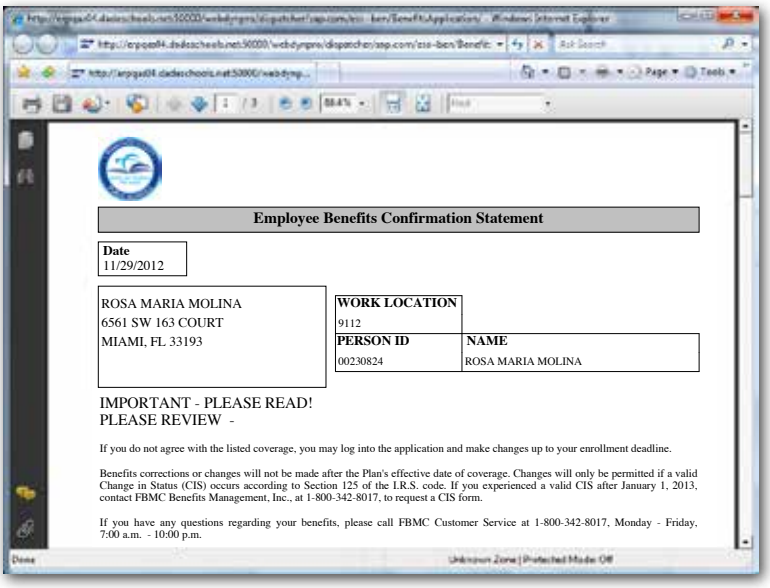
How to Enroll Online

www.dadeschools.net

10 Employee Benefits Confirmation Statement

Click to print a copy of your Employee Confirmation Statement.

When done printing, click **X** to close this window and return to the Enrollment Process.



Employee Benefits Confirmation Statement

Date
11/29/2012

ROSA MARIA MOLINA
6561 SW 163 COURT
MIAMI, FL 33193

WORK LOCATION	
9112	
PERSON ID	**NAME**
00230824	ROSA MARIA MOLINA

IMPORTANT - PLEASE READ!
PLEASE REVIEW -

If you do not agree with the listed coverage, you may log into the application and make changes up to your enrollment deadline.

Benefits corrections or changes will not be made after the Plan's effective date of coverage. Changes will only be permitted if a valid Change in Status (CIS) occurs according to Section 125 of the I.R.S. code. If you experienced a valid CIS after January 1, 2013, contact FBMC Benefits Management, Inc., at 1-800-342-8017, to request a CIS form.

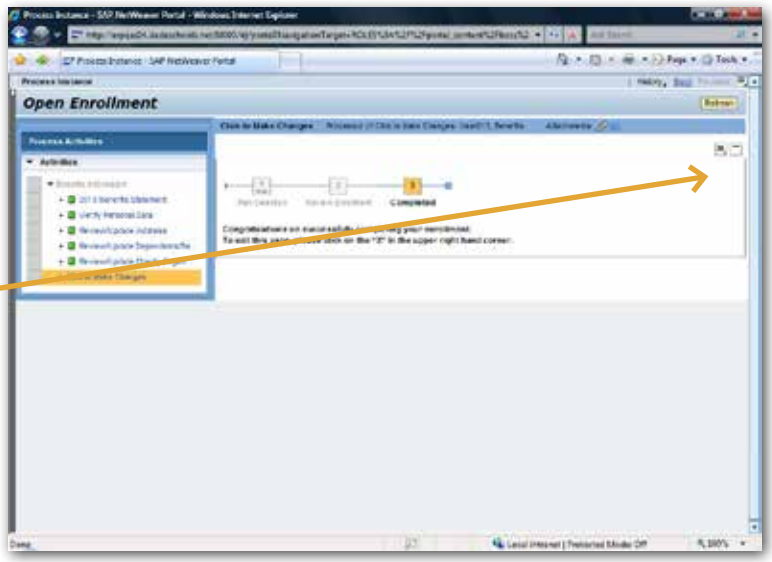
If you have any questions regarding your benefits, please call FBMC Customer Service at 1-800-342-8017, Monday - Friday, 7:00 a.m. - 10:00 p.m.

11 Congratulations on successfully completing your enrollment.

When you see this message, it confirms that your submissions have been received.

If you need to make changes before the enrollment deadline date, please return to **Click and Make Changes** and you will automatically be redirected to the selection screen.

To exist this page, please the click **X** in the upper, right corner.



CURRENT EMPLOYEE Open Enrollment Facts

1Q. What is the Open Enrollment Period?

A. The Open Enrollment Period is a period of time, determined by your employer, during which you are allowed to make any changes to your current benefits. This year is December 3, 2012 through December 14, 2012 for employees, except FOP.

NOTICE: No changes are allowed after the commencement of a new plan year (see Page 31 for the Change in Status section for exceptions).

2Q. Must all eligible employees enroll for benefits effective January 1, 2013?

A. **No.** This is a changes only enrollment. If you do not make any changes, your current benefit coverage will continue. You must view your Benefits Statement via the Employee Portal.

3Q. What if I decline healthcare coverage?

A. If you are opting out of M-DCPS healthcare, you must provide documentation of other group or state-funded healthcare coverage. If documentation is not produced, you will be automatically assigned to Cigna OAP 20 employee-only coverage.

4Q. What do I need to submit to ensure that my dependents have coverage?

A. You will need to submit dependent eligibility verification before the start of this plan year. If not, your dependent may be terminated. (See Page 26 for the list of acceptable documents.)

5Q. What is my effective date when enrolling during the enrollment period of December 3, 2013 - December 14, 2013?

A. The effective date for these benefits is January 1, 2013 and the first deduction will be taken on payroll January 11, 2013.

6Q. If I am hired during this Open Enrollment period, must I enroll for the current plan year as well as the next plan year?

A. For Plan Year 2012, you will be automatically assigned to Cigna OAP 20 Employee-only. However, you must enroll during this Open Enrollment period for benefits, effective January 1, 2013.

7Q. What changes can I make during the Open Enrollment?

A. During this period, you may purchase benefits, delete or add dependents. Any dependent child who turned 26 in the year 2012 (born in 1985) cannot be covered or be added for 2013 benefits during the open enrollment period as a regular dependent. See Page 29 for provision for adult dependents. If a covered dependent is disabled, proof must be submitted in order for coverage to continue beyond 26 years of age.

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

8Q. How will I know when I can enroll?

A. You will be permitted to enroll during your Bargaining Unit's open enrollment period. You will receive an e-mail specifying your Bargaining Unit's enrollment dates.

9Q. When is the last day to make changes for benefits effective, January 1, 2013?

A. If making changes, you must complete your online enrollment selections by midnight on December 14, 2012.

10Q. What happens if I do not re-enroll by the enrollment deadline?

A. If you do not re-enroll by the end of the open enrollment period, your current benefits and those of your dependents will continue. Your plan design changes and premium changes will automatically be adjusted.

11Q. What if I do not have a computer or Internet access available?

A. If you do not have access to the Internet, you may visit the Office of Risk and Benefits Management for assistance at 1501 NE 2nd Avenue, Suite 335. Enrollment Assistance is available weekdays from 8 a.m. to 4:30 p.m., during this open enrollment period. Additionally, representatives will be at select work locations throughout the enrollment to assist with your enrollment.

12Q. What if I enroll and I want to change my benefits selection?

A. You may log on to the Internet and change your benefits selection as many times as you want throughout the open enrollment period. Your last **saved** and **submitted** selection will be your benefits, effective January 1, 2013. Changes made during the open enrollment period of December 3, 2012 through December 14, 2012 will be effective, January 1, 2013.

CURRENT EMPLOYEE Open Enrollment Facts

13Q. Can I decline Healthcare coverage?

A. Yes. You may decline healthcare coverage. You must provide proof of other group or state-funded program coverage. Enrollment in an individual healthcare plan coverage does not qualify. Additionally, you must **agree** to the provision set forth on the affidavit. Refer to Page 78.

14Q. If I decline healthcare coverage, what happens to the Board contribution toward my healthcare coverage?

A. In lieu of healthcare coverage, you will receive $100 per month paid on a bi-weekly through the payroll system, based on your deduction pay schedule (subject to withholding and FICA) as follows:

- 10-month employees will receive their payment in 20 pay checks.
- 11-month employees will receive their payment in 24 pay checks.
- 12-month employees will receive their payment in 26 pay checks.

If you do not provide proof of other group healthcare coverage, you will be automatically assigned the Cigna Open Access Plus 20 (employee-only) healthcare plan and standard Short-Term Disability.

If electing, during this open enrollment, to decline healthcare coverage, you are required to submit proof of enrollment in other group or state-funded program, even if previously submitted.

15Q. Can I select coverage for myself through one healthcare plan and another for my family?

A. No. You and your eligible dependents must be covered with the same healthcare plans.

16Q. Can I select coverage for myself through one FlexPlan benefit provider and another for my family?

A. No. You and your eligible dependents must be covered with the same FlexPlan benefit and provider.

17Q. How do I view the Cigna Healthcare or FlexPlan Provider Directories?

A. Go to the www.dadeschools.net Employee Link button, then click on the Provider Directory of the company you desire.

Confirmation of Benefits

18Q. Will I be able to view and print a confirmation of my 2013 benefits selection?

A. Yes. Everyone is able to view and print their Benefits Confirmation Statement online, immediately after benefit selections are saved successfully.

A benefits notice is automatically generated and presented at the end of your enrollment session.

Additionally, if not making changes, you can view your Benefits Confirmation Statement and verify you are rolling your current benefits over to next year. The Benefits Statement will reflect the new rates for 2013.

Effective Date of Coverage

19Q. When are benefits for the new plan year effective and for how long?

A. This enrollment is for benefits, effective January 1, 2013 through December 31, 2013. Changes made during the open enrollment period of December 3, 2012 through December 14, 2012, become effective January 1, 2013 and will continue through December 31, 2013 as long as your full-time employment continues.

Termination Date

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

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

NEW EMPLOYEE Open Enrollment Facts

You will receive an e-mail notifying you that your enrollment application is available.

Open Enrollment Facts For New Employees

1Q. Must all new employees enroll?

A. Yes. You must complete your enrollment by logging on to **www.dadeschools.net.**

2Q. What is the deadline for completing my online enrollment?

A. Your initial enrollment period is 30 calendar days from the date of hire. Enrolling in this time frame will ensure that you receive the benefits of your choice.

3Q. Can I elect not to be covered?

A. In lieu of healthcare coverage, you will receive $100 per month paid on a bi-weekly through the payroll system based on your deduction pay schedule (subject to withholding and FICA) as follows:

- 10-month employees will receive their payment in 20 pay checks.
- 11-month employees will receive their payment in 24 pay checks.
- 12-month employees will receive their payment in 26 pay checks.

If you do not provide proof of other group healthcare coverage, you will be automatically assigned the Cigna Open Access Plus 20 (employee-only) healthcare plan and standard Short-Term Disability coverage.

If electing, during this open enrollment, to decline healthcare coverage, you are required to submit proof of enrollment in other group or state-funded program, even if previously submitted.

4Q. What if I do not enroll?

A. If you do not complete your enrollment in the allotted time:

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

5Q. What if I do not have a computer or Internet access available?

A. If you do not have access to the Internet, you may visit the Office of Risk and Benefits Management for assistance at 1501 NE 2nd Avenue, Suite 335, weekdays from 8 a.m. to 4:30 p.m. ET.

6Q. What if after I enroll I want to change my benefits selection?

A. You may change your benefits selection as many times as you wish until the end of your initial enrollment period.

7Q. Can I select coverage for myself through one healthcare plan benefit and another for my family?

A. No. You and your eligible dependents must be covered with the same Healthcare plans.

8Q. Can I select coverage for myself through one FlexPlan benefit provider and another for my family?

No. You and your eligible dependents must be covered with the same FlexPlan benefit and providers.

9Q. How do I view the Cigna or FlexPlan Provider Directories?

A. Go to the www.dadeschools.net Employee Link button, then click on the Provider Directory of the company you desire.

Confirmation of Enrollment

10Q. If electing dependent coverage or employee-paid benefits, when will my first deduction be taken and what's the effective date on these benefits?

A. The first deduction for benefits will be taken on the last paycheck of the month in which you enroll and your benefits are processed. The effective date is the first of the following month after that first deduction is taken.

Frequently Asked Questions

Effective Date of Coverage

1Q. When are benefits for the new plan year effective and for how long?

A. Current employee benefits become effective on January 1, 2013 of this plan year and continue through December 31, 2013, as long as full-time employment is continued. Should employment terminate, coverage will cease at the end of the calendar month in which employment terminates. Benefits will remain in effect through August 31 for 10-month employees who terminate employment during the last month of the school year.

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

COBRA

2Q. When will coverage terminate for my dependent child when he/she reaches age 26?

A. If your dependent child reaches age 26 in the 2013 Plan Year (born in 1987), coverage for the ineligible dependent will be terminated at the end of the current plan year.

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

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

- Does not have a dependent of his or her own
- Is a resident of Florida, and
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.
- In addition, currently covered adult children who turned age 30 in 2012 are eligible for COBRA and an enrollment package will be sent.

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

3Q. How can my qualified dependent continue coverage under medical, dental or vision plans

A. Within 30 days from the date of loss of eligibility, your qualified dependent must notify the COBRA Representative in the Office of Risk and Benefits Management at 305.995.1285, 305.995.1738 or 305.995.7169. A qualifying event notice and an application will be forwarded to the qualified dependent within 30 calendar days.

4Q. How long does the qualified dependent have to make his/her COBRA elections?

A. The qualified dependent has a 60-day period from the date of notification to elect whether to continue coverage. Once a qualified dependent has elected COBRA, he/she has 45 days to pay for the coverage. COBRA is retroactive if elected and paid for by the qualified dependent. Initial payment must be for coverage of the initial COBRA effective date for the current month. No payment arrangement can be made.

5Q. What are the periods of coverage for COBRA qualifying events?

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

You may elect to continue your Medical Expense FSA and continue to receive reimbursements through the end of the plan year. To continue your Medical Expense FSA, contact a COBRA Representative at 305.995.7169, 305.995.1285 or 305.995.1738.

Board-Approved Leave of Absence

6Q. If I take a Board-approved leave of absence, whom do I contact about my benefits?

A. Once your leave is approved and the Office of Risk and Benefits Management receives notification, you will be eligible for applicable benefits according to your Bargaining Unit and type of leave. You will be billed for employer-paid benefits in accordance to the type of leave and labor contract. Additionally, you will be billed for employee-paid benefits.

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

For questions regarding your benefits while on leave, please call 305.995.7129 and ask to speak with a leave billing specialist.

Frequently Asked Questions

7Q. What if I am unable to pay premiums while on leave?

A. The benefits for which you have been billed will be cancelled, if payment is not received by the due date. Any claims incurred will not be paid, unless otherwise provided by law. If you return to work and your coverage is still active, owed premiums will automatically be taken from your paychecks.

Cancelled employer-paid benefits will be automatically reinstated upon your return to work. However, in order to reinstate any employee-paid benefits cancelled, due to non-payment while on leave, you must request a Change in Status Election form. See the Changes in Status event information on Page 31 for further details.

Benefits at Retirement

8Q. If I retire, whom do I contact for benefits information?

A. When you complete your retirement papers, the Retirement Office will notify the Office of Risk and Benefits Management and a package will be mailed to your home, containing the information you need to continue your healthcare coverage, life insurance benefits and flexible benefits plans after you retire.

You will have 30 days from the date of notification to select your benefits. Only those dependents which were covered under your medical and flexible benefits plan, at the time of your retirement, will be eligible to continue coverage. You may add or drop dependents during the annual Open Enrollment for retirees. You may only continue life insurance and accidental death and dismemberment at the same level in effect at your retirement. If you retire while on a leave of absence and have no active healthcare and/or flexible benefits at retirement, you will not be eligible to enroll in any benefits not in effect. If you retired and had declined healthcare coverage, you will not be eligible to enroll as a retiree in healthcare coverage, even if you are Medicare eligible. You may contact the Office of Risk and Benefits Management at 305.995.7129 for questions.

Termination of Employment

9Q. Does my insurance coverage end when I terminate my employment?

A. Benefits for you and your dependents continue to the end of the calendar month in which you terminate employment. However, benefits for 10-month employees who terminate at the end of the school year remain in effect through August 31, provided you work during the last month of the school year.

NOTE: Benefits for which total premiums have not been collected cannot be continued after termination of employment.

10Q. Can I continue my own and my dependents' medical, dental and vision coverage if I terminate employment?

A. Yes. According to federal and state law, you can continue your own and/or your dependents' coverage for currently enrolled medical, dental and/or vision for a period of 18 months following a termination of employment by applying for COBRA. You will be notified of these rights when you terminate. You may also call the Office of Risk and Benefits Management at 305.995.7169, 305.995.1285 or 305.995.1738 and speak to a COBRA Representative to inquire further on what benefits will be available to you.

11Q. Can I continue my Board Life insurance if I terminate?

A. You may apply for a conversion policy for all or any portion of your or your dependents' life insurance in effect at termination. You must complete a conversion application, which is available from Metropolitan Life Insurance Company by calling 305.995.7029 within 31 days of termination.

12Q. What happens to my FSA contributions if I terminate employment or retire?

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

Remember, you have until April 15, 2014, to submit a request for reimbursement for expenses incurred before your benefits end date. See the Flexible Spending Accounts section of this guide for more details.

Claims and Claim Forms

13Q. What claim form must I complete for my dental and vision benefits?

A. Claim forms are available at the Office of Risk and Benefits Management or online at **www.dadeschools.net**. Click on Employee Benefits, then on the Claim Form link.

14Q. When do I request a claim form for my Short-Term and Long-Term Disability?

A. The Hartford must receive notification no later than 90 days after your elimination period. You must notify The Hartford at 1.800.741.4306.

Frequently Asked Questions

How does the Flexible Benefits Plan affect other benefits?

Your Retirement Benefits

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

Tax Sheltered Annuity

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

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

Social Security

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

However, the tax savings realized through the Flexible Benefits plan generally outweigh the Social Security reduction. Call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262) for an approximation.

Itemized Deductions

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

Pre-tax/Post-tax

Employees who wish to have their 2013 premiums deducted POST-TAX may do so by indicating so during their enrollment. If a selection is not made, applicable deductions and employer contributions will continue on a pre-tax basis. Regardless of your selection, Flexible Spending Accounts are always PRE-TAX. Your Legal Plan, SeniorAdvocate Plan, and Long-Term Disability (LTD) are always POST-TAX.

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

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

A Domestic Partner and the child(ren) of a Domestic partner are eligible. According to IRS (Internal Revenue Service) Section 125 Regulations, all deductions for employee-paid benefits for domestic partner coverage must be taken on a post-tax basis. Additionally, employees must pay the tax liability on the monthly contribution (subsidy) the Board pays on the employee's behalf for any type of Domestic Partner coverage. Therefore, the value of these benefits will be added to your taxable income and your W-2 will be adjusted to reflect the higher income level annually.

**Please see each product page for specific dependent eligibility information. Eligibility for healthcare, dental, and vision will be verified by the contract administrator, FBMC Benefits Management. For a list of required documentation, see Page 26. If proof is not submitted by December 31, 2012, the dependent coverage will be terminated and claims will not be paid. If dependent coverage is terminated and premiums were deducted, refunds will not be automatically issued. To request a refund, if applicable, contact Payroll Deduction Control at 305.995.1655. All other benefits will be verified by the individual insurance company at the time a claim is filed. Please refer to Page 26 for required documentation.

Over-the-Counter Expenses

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

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

Eligible Over-the-Counter (OTC) drugs and medicines require a prescription from your physician to qualify for reimbursement. It's important to remember that you can still use your FSA funds for other eligible medical expenses and prescription purchases at pharmacies. Non-drug and non-medicine items that aren't subjected to new OTC laws may still be purchased normally. Please visit **www.myFBMC.com** for more information. If you have any questions, please contact the Service Center.

Dependent Eligibility

You must submit dependent documentation for all covered dependents, even if previous submitted.
Please refer to Page 26 for further details.

Who Is Eligible for Coverage*

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

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

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

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

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

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

NOTE: A Domestic Partner and the child(ren) of a Domestic Partner are eligible. They do not qualify for IRS Section 125. All employee-paid benefits will be on a post-tax basis. Additionally, you must pay the tax liability on the monthly contribution (dependent subsidy) that the Board pays on your behalf. Therefore, the value of these benefits will be added to your taxable income and your W-2 will be adjusted to reflect the higher income level annually. Domestic Partners or their child(ren) who do not meet the eligibility criteria, will have benefit(s) coverage terminated and any claims incurred will not be paid. All other selected employee-paid benefits will continue for the remainder of the plan year on a post-tax basis. The Domestic Partner must also be included in that coverage. Domestic Partners and/or their children do not qualify as eligible dependents for FSA Reimbursement.

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

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

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

NOTE: Your newborn will be covered free of charge (no premium) for the first 31 days. During these 31 days, you are still required to satisfy the deductible and co-insurance. However, You must call and request a Change in Status (CIS) form within the 30 days for coverage to become active.

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

Disabled Children: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the benefits. The eligible disabled dependent can only remain enrolled in the benefits they were enrolled in at the time of disability. However, if coverage is terminated, it cannot be reinstated even during Open Enrollment. Proof of disability (Social Security disability papers) must be provided to FBMC - 1501 NE 2nd Avenue, Suite 335, Miami, FL 33132.

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

Dependent Eligibility

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

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

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

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

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

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

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

Flexible Spending Accounts

In compliance with the Patient Protection and Affordable Care Act (PPACA Healthcare Reform), effective January 1, 2013, the Medical Expense FSA annual maximum contributions has changed to $2,500.

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

1) That person lived with you for the entire year as a member of your household or is related to you
2) That person was a U.S. citizen or resident, or a resident of Canada or Mexico for some part of the calendar year in which your tax year began, and
3) You provided over half of that person's total support for the calendar year. You can include the medical expenses of any person who is your dependent, even if you cannot claim an exemption for him or her on your return. Domestic Partners and their children are ineligible.
   NOTE: Certain Over-the-Counter (OTC) drugs and medicines requires a prescription to qualify for FSA reimbursement. It's important to remember that you can still use your FSA funds for other eligible medical expenses and prescription purchases at pharmacies. Unaffected OTC items-are still reimbursable, as well as affected OTC items with a doctor's prescription. Please visit **www.myFBMC.com** for more information. If you have any questions regarding this legislation, please contact the Service Center.

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

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

A partial list of eligible dependent care expenses, include:
- babysitting fees
- day care services
- elder care services
- summer day camps

Additional information is found on Page 95.

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

Online Claims Submission Instructions

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

PLEASE NOTE:
- Acceptable document formats are .pdf .jpg, .bmp or .gif.
- Individual file sizes cannot exceed 3 megabyte.
- Be sure to have your completed claim form and supporting documentation scanned before beginning the process. Refer to your scanner's instruction manual for information on saving your documents in the proper format and within the acceptable file size limit.

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

Important Notice:

- Please note that your deductions may change during the calendar year a result of missed payrolls. If while still employed you miss a paycheck, the system will automatically recalculate your annualized amount and adjust your per pay to assure that your requested annual contribution is satisfied.
- If you do not make changes to your current benefits and are contributing over the new annual maximum, your annual contribution will automatically be changed to $2,500.

Dependent Documentation Requirements

Dependent documentation is required for all dependents for the 2013 Plan Year.

Dependent Relationship	Documentation Requirements	
Spouse	Marriage Certificate	
Natural Child	Birth Certificate (must list employee as a parent) **NOTE:** birth registration, SS card or passport is not valid proof	
Stepchild	Birth Certificate (must list employee's spouse as a parent) and Marriage Certificate.	
Adopted Child	Court Documentation of adoption	
Legal Custody or Guardianship	Court documentation defining guardianship or legal custody. **NOTE:** Notarized affidavit is not acceptable documentation. Temporary custody does not constitue legal custody.	
Disabled Dependents Over Age 26	Social Security Disability Documentation. Disabled dependents are eligible only if covered by a School Board Healthcare plan or Flexible Benefits plan prior to the date of disability. Additionally, if coverage is terminated, it cannot be reinstated.	
Adult Child (between the age of 26–30)	• Affidavit of Eligibility • Birth certificate or Court Documents of Adoption/guardianship/legal custody • Proof of Florida Residence (Florida Driver License)	
Grandchildren For specific eligibility requirements, see each benefit's page.	**UNDER 18 MONTHS OLD** Birth Certificate (must list employee's child as a parent) **NOTE:** the parent must be a covered dependent; if not, same as Legal Custody or Guardianship	**OVER 18 MONTHS OLD** Legal Custody or Guardianship documentation

Dependent Eligibility Documentation

Print, complete and include this form with the required documentation.

Return To: School Mail:
WL 9112
Suite 335

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

Fax To: 305.995.1425

Employee Number _____

Social Security Number _____

Employee Name _____

Important Information

- Proof of eligibility must be on file for all listed dependents.
- You must submit proof of eligibility by the deadline. Otherwise, coverage may be terminated for any dependent whose eligibility has not been verified. Claims incurred will not be paid and any premiums deducted will not be automatically issued.
- If not previously submitted, You must provide your covered dependent's Social Security number.

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

Employee Signature_____ Date_____

Domestic Partner Eligibility

Documentation Requirements

Relationship	Documentation Requirements
Domestic Partner A copy of the Domestic Partnership Affidavit is available on Page 28 of this online Benefits Guide.	Affidavit of Domestic Partnership and any two of the following, demonstrating a minimum of a year (12 consecutive months) partnership: • Joint mortgage or lease of residence • Joint ownership of a motor vehicle • Joint bank or investment account • Joint credit card or other financial responsibility • Will naming the partner as the beneficiary • Life Insurance policy naming the partner as the beneficiary • Assignment of durable power of attorney or healthcare proxy
Children of Domestic Partner	Birth Certificate (must list Domestic Partner as a parent) and Domestic Partner documentation as defined above. **NOTE:** Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner with children" coverage.
Grandchildren of Domestic Partner	Birth Certificate (must list Domestic Partner's child as a parent) and children of Domestic Partner documentation as defined above. **NOTE:** Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner with children of a Domestic Partner" coverage. Legal Custody or Guardianship documentation

Important Information

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

Employee Number _____

Employee Name _____

Social Security Number _____

PRINT AND RETURN BY U.S. MAIL TO:
Office of Risk & Benefits Management
1501 NE 2nd Avenue, Suite 335
Miami, FL 33132

RETURN BY SCHOOL MAIL TO:
Work Location 9112, Suite 335

OR FAX TO: 305.995.1425

Indicate the relationship of your dependent on the form below.

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

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

Employee Signature_____ Date_____

NOTE: This is not an enrollment form, you must still complete your benefits enrollment and return it with both the dependent documentation and the notarized Domestic Partner Affidavit.

Affidavit of Domestic Partnership

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

- We are each eighteen years of age or older and mentally competent.
- We are not related by blood in a manner that would bar marriage under the laws of the State of _____.
- We have a close and committed personal relationship, and we are each other's sole domestic partner, not married to or partnered with any other spouse, spouse equivalent or domestic partner.
- For, at least, one year, we have shared the same regular and permanent residence in a committed relationship and intend to do so indefinitely.
- We have provided true and accurate required documentation, demonstrating a minimum of a year (12-consecutive months) of partnership.
- Each of us understands and agrees that in the event any of the statements set forth, herein, are not true, the insurance or healthcare coverage for which this Affidavit is being submitted may be rescinded and/or each of us shall jointly and severally be liable for any expenses incurred by the employer, insurer or healthcare entity.
- I understand that, per IRS Section 125, all deductions for employee-paid benefits will be taken on a post-tax basis.
- I understand that I must pay the tax liability on the monthly contribution (dependent subsidy) that the Board pays on my behalf.

_____ _____

Employee Name (Print Name) Domestic Partner (Print Name)

_____ _____

Signature Signature

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

_____

NOTARY PUBLIC

Return To: School Mail:
WL 9112
Suite 335

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

Fax To: 305.995.1425

Adult Child Notice

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

In order to continue coverage of your currently to enroll your Adult Child, you must re-submit the dependent eligibility documentation by the December 14, 2012 enrollment deadline. The dependent eligibility documentations can be faxed to 305.995.1425 or sent via school mail to WL9112 Office of Risk and Benefits Management.

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

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

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

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

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

NOTE: To continue to cover or add your adult child dependent, you must re-submit dependent eligibility documentation with your enrollment form. If dependent eligibility is not received, your current, covered adult child will be cancelled December 31, 2012.

Adult Dependent Healthcare Premiums:

Cigna HEALTHCARE	PER PAY RATE PER ADULT DEPENDENT CHILD
Open Access Plus (OAP) 20	10-month $319.80, 11-month $266.50, 12-month $246.00
Open Access Plus (OAP) 10	10-month $293.40, 11-month $244.50, 12-month $225.69

If you are covering other children, your adult child must be covered under the same healthcare plan, and the adult dependent premium is in addition to the under age 26 children rate. Adult child rates are not subsidized by the Board.

To add an Adult Child, you must request an Adult Dependent enrollment package. Call the Cigna Representative at 305.995.2883 , Monday through Friday, 7 a.m. to 8 p.m. An enrollment form and Affidavit of Eligibility will be mailed to your home address the following business day. Your completed form, affidavit, and dependent eligibility documentation must be received by the due date noted on the form.

Adding/Dropping Your Dependents During the Plan Year

1Q. Can I add or delete dependent coverage and make changes in my benefit elections during the year?

A. A participant is permitted to make changes to his or her elections mid-plan year only for a legitimate Change in Status (CIS). Meaning, "on account of and corresponding with a Change in Status that affects eligibility for coverage." If you experience a qualifying CIS Event, the election changes must be requested and submitted with proper documentation within 30 days from the qualifying event and the change must be consistent with the type of event. However, you cannot change your medical or dental plan insurance provider. You may add dependents to your existing coverage or delete your dependents. Please refer to the Change in Status events information on Page 31 of this guide.

2Q. If I experience a CIS event, how and when must I request the CIS form in order for the change to be approved?

A. You must call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262) within **30 days** from the date of the valid event and request a Change In Status Election Form.

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

3Q. When I add dependents through a CIS event, when do their benefits become effective?

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

** **Your newborn will be covered free of charge for the first 31 days. However, you are still responsible for the claims incurred on the date of birth.** Your newborn child is not automatically enrolled by your employer or group health plan. **You must add your newborn dependent within 30 days, even if your current coverage includes employee and children, or employee and family coverage or employee and Domestic Partner and their child(ren). Don't forget to include the proper documentation when adding a dependent. See Page 23 through 30 of this guide for more details.**

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

4Q. When I delete a dependent through a Change In Status, when does their coverage terminate?

A. Coverage for your dependent(s) is terminated effective the last day of the month in which the form is processed – after receipt of a completed Change in Status form and supporting documentation. Coverage is never terminated retroactively.

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

5Q. If I decline School Board healthcare coverage, but I lose my other coverage, can I re-enroll under a School Board plan mid-year?

A. You may only enroll in a School Board healthcare plan mid-year if you have lost other **group or state funded** insurance coverage. Supporting documentation will be required. The effective date of your School Board healthcare plan is the first of the month following the processing of your Change In Status. Enrollment in an individual policy does not qualify.

Domestic Partners & their Child(ren)

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

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

- Each eighteen years of age or older and mentally competent
- Have a close and committed personal relationship, and are each other's sole domestic partner not married to or partnered with any other spouse, spouse equivalent or domestic partner
- Have provided true and accurate required documentation of their relationship, and
- Each understands and agrees that in the event any of the statements set forth on the affidavit are not true, the insurance or health care coverage for which the Affidavit is being submitted may be rescinded and/or each shall jointly and severally be liable for any expense incurred by the employer, insurer or healthcare entity.
- Employee-paid benefits will be taken on a post-tax basis.
- Employee must pay tax liability on the monthly contribution (dependent subsidy) that the Board pays toward dependent coverage.
- Must present two forms of documentation demonstrating a minimum of a one year (12 consecutive months) of partnership.

Please see Page 31 for Change in Status Events.

Change in Status Events (CIS)

Mid-Year Benefit Changes In Status (CIS)

Forms must be requested and submitted with proper documentation within 30 days from the date of the event listed below. You must contact the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262) for a CIS election form. Appropriate documentation supporting the Change in Status Event is required when returning the form.

Marital Status

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

Change in Number of Eligible Dependents

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

Change in Status of Employment Affecting Coverage Eligibility

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

Gain or Loss of Dependents' Eligibility Status

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

Change in Residence

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

Open Enrollment Under Other Employer's Plan

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

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

* Does not apply to a Medical Expense FSA.

Judgement/Decree/Order

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

*Does not apply to Dependent Care FSA.

Medicare/Medicaid/Kidcare

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

HIPAA

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

Other Election Changes

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

Healthcare Q&A

Effective January 1, 2013

1Q. What are my co-pays for a physician office visit?

A. An office visit is covered 100% after the following co-pays for In-network providers: In-network primary care physicians at $25 co-pay. Cigna Care Network (CCN) specialists at $50 co-pay. In-network Non CCN specialists at $70 co-pay.

2Q. What is a Cigna Care Network (CCN) specialist?

A. These are specialists of a designated network that have been identified by Cigna to have demonstrated the best outcome in management of patient treatment.

3Q. What specialties are included in this network?

A. There are 19 different specialties, and 1,725 CCN providers are located in South Florida.

4Q. How do I determine if my specialist is on the CCN network?

A. You may access the CCN provider network at **www.Cigna.com**. Click on the Welcome link, then on the Find a doctor link, then click on Physicians, data enter your zip code and click on next. Then select "Open Access Plus, OA Plus with CareLink (second bullet), then click on Specialist and a list of participating CCN provider, with a tree of life symbol next to their name will appear. On the website, the symbol of a "leaf" will be next to the physician's name.

5Q. How does the annual deductible work?

A. The annual deductible is the amount you are responsible for and is separate from any co-payments. Deductibles are expenses to be paid by you or your dependent(s) for medical services provided in a hospital or hospital-affiliated facility.

6Q. How much is the deductible?

A. • OAP 20 - the in-network annual maximum deductible is $750/individual and $1,500/family. Out-of-network is $1,500/individual and $3,000 family.

• OAP 10 - The in-network annual maximum deductible is $500/individual and $1,000/family. Out-of-network is $1,000/individual and $2,000/family.

7Q. What does the annual maximum out-of-pocket (MOOP) mean?

A. The annual out-of-pocket maximum is the amount you are responsible for before the plan pays 100%. Deductibles and set dollar amount co-pays do not apply to the out-of-pocket maximum.

• OAP 20 - in-network out-of-pocket maximum is $2,000 per individual or $4,000 per family. Out-of-network pocket maximum is $6,500 for individual and $13,000 for family.

• OAP 10 - in-network out-of-pocket maximum is $2,000 per individual or $4,000 per family. Out-of-network pocket maximum is $3,500 for individual and $7,000 for family.

8Q.What does the plan co-insurance mean?

A. The plan co-insurance is the percentage that the insurance will pay on covered services after you have satisfied the annual deductible.

• OAP 20 Plan will pay 70% in network and 50% out-of-network.

• OAP 10 Plan will pay 80% in network and 60% out-of-network.

9Q. What services do the co-insurance percentages apply to?

A. Co-insurance percentages apply to all services provided in a hospital or hospital-affiliated facility, and that do not have a fixed co-pay (dollar) amount.

10Q. What happens if I am hospitalized?

A. OAP 20 - Hospital admissions are subject to 30% of allowable charges after the $750 deductible for employee-only & $1,500 for family.

Out-of-network hospital admissions are subject to 50% of allowable charges after $1,500 deductible for employee-only & $3,000 for family.

OAP 10 - Hospital admissions are subject to 20% of allowable charges after the $500 deductible for employee-only & $1,000 deductible for family.

Out-of-network hospital admissions are subject to 40% of allowable charges after $1,000 deductible for employee-only & $2,000 for family.

For example: if you are hospitalized in an in-network hospital:

	OAP 20	OAP 10
Deductible:	$750 Individual	$500 Individual
Co-Insurance:	30%	20%
Out-of-pocket:	$2,000 Individual	$2,000 Individual
Maximum Cost:	$2,750 Individual	$2,500 Individual

Healthcare Q&A

Effective January 1, 2013

11Q. What are the co-pays for emergency room visit?

A. In-network emergency room charges are paid 100% after your $300 co-pay. Jackson Hospital System emergency room charges are paid 100% after your $150. The emergency room co-pay is waived, if you are admitted.

12Q. What are the co-pays for urgent care centers?

A. In-network urgent care charges are paid 100% after your $70 co-pay.

• OAP 20 - Out-of-network urgent care charges are paid at 50% after deductible.

• OAP 10 - Out-of-network urgent care charges are paid at 60% after deductible.

13Q. What are the co-pays for convenience care centers?

A. In-network convenience care charges are paid 100% after your $10 co-pay.

• OAP 20 - Out-of-network convenience care charges are paid at 50% after the plan deductible is met.

• OAP 10 - Out-of-network convenience care charges are paid at 60% after the plan deductible is met.

14Q.Prescription Drugs Retail (up to 31 day supply)

A.

Tier 1 -	$15	Generic Medications
Tier 2 -	$40	Preferred Brand Medications (when generic is not available)
Tier 3 -	50%	Co-insurance (minimum $100 & maximum $150) Non-Preferred Brand Medications (These medications have a generic or a Tier 2 alternative within the same drug class.)

OAP 20 - Out-of-network pharmacies prescriptions are covered at 50%.
OAP 10 - Out-of-network pharmacies prescriptions are covered at 50%.

15Q. 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-pay of two times the tier cost, saving you time and money. The co-pays for this benefit are as follows:

Tier 1 -	$30	Generic Medications (2x$15)
Tier 2 -	$80	Preferred Brand Medications (when generic is not available) (2x$40)
Tier 3 -		2 times 50% co-insurance (minimum $100 & maximum $150) (2x50% maximum $100-$300)

16Q. 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.

17Q. 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.

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% out-of-network.

• OAP 10 Plan will pay 80% in-network and 60% out-of-network.

Once you have met your maximum out-of-pocket, the coverage will be 100%.

Examples of DME are: wheelchair, crutches, walkers, CPAP, hospital bed, etc.

19Q. Can I decline healthcare coverage?

A. Yes, you can decline healthcare coverage and, in lieu, 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 OAP 20 employee-only coverage.

Healthcare Q&A

Effective January 1, 2013

20Q. Is there a cost when enrolling in Cigna OAP20?

A. No, OAP 20 remains free. No cost for employee-only coverage.

21Q. Will M-DCPS continue to subsidize the cost of dependent premium?

A. Yes, M-DCPS will continue to subsidize dependent premium 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.

23Q. Must all eligible employees enroll during this enrollment period for benefits, effective January 1, 2013?

A. No, this is a changes only enrollment and if you do not re-enroll during this open enrollment period, your current benefits 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 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 OAP 20, 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 1.855.5MYFBMC (1.855.569.3262), Monday through Friday, 7 a.m. – 8 p.m. ET

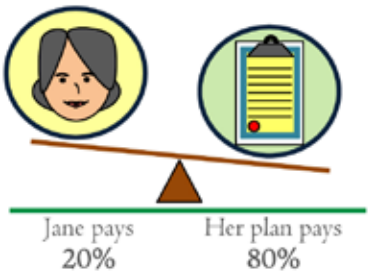
Glossary of Health Coverage and Medical Terms

- 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.

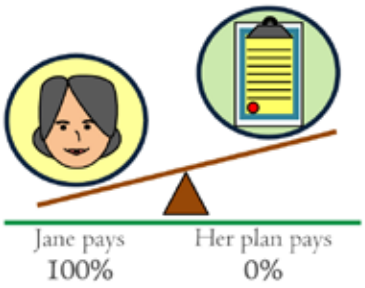
Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered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

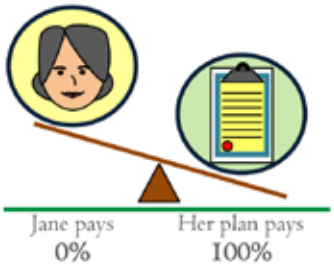
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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.

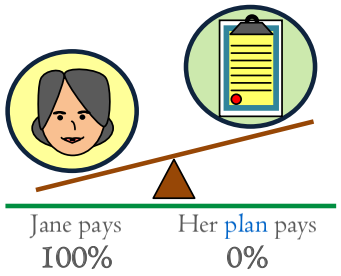
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

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

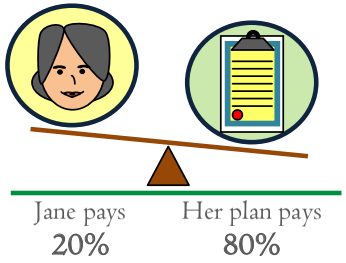
January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



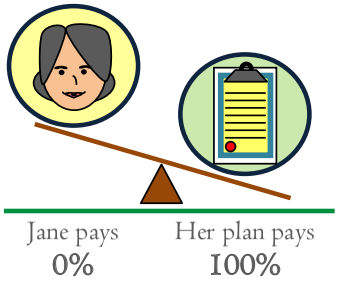
Jane hasn't reached her $1,500 deductible yet
Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs



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

more costs



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

Open Access Plus: Miami-Dade County Public Schools

Coverage Period: 01/01/2013 - 12/31/2013

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

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$500** person / **$1,000** family For out-of-network providers **$1,000** person / **$2,000** 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**.	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**.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$2,000** person / **$4,000** family / For out-of-network providers **$3,500** person / **$7,000** family	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.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, co-payments, plan deductibles, penalties for no pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.myCigna.com or call 1-800-806-3052	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**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **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	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	40% co-insurance after plan deductible	In-network convenience care clinic visit- $10 co-pay/visit
	Specialist visit	CCN Specialist: $50 co-pay/visit Non-CCN Specialist: $70 co-pay/visit	40% co-insurance after plan deductible	Contact Cigna for Cigna Care Network specialties information
	Other practitioner office visit	$70 co-pay/visit for chiropractor	40% co-insurance after plan deductible	Coverage for Chiropractic services is limited to 30 days annual max.
	Preventive care/screening/immunization	No charge	Not Covered	Preventative care and immunizations for children through age 15 are covered out-of-network with 40% co-insurance and no deductible. Well Woman exam is covered out-of-network with 40% co-insurance after plan deductible. .

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	**Xray:** Non-Hospital Based $100 co-pay **Blood Work:** No Charge	40% co-insurance after plan deductible	Xray In-Network Hospital Based or Affiliated is 20% co-insurance after plan deductible
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based $100 co-pay per type of scan/day	40% co-insurance after plan deductible	In-Network Hospital Based or Affiliated is 20% co-insurance after plan deductible
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com	Generic drugs	$15 co-pay/prescription (retail), $30 co-pay/prescription (home delivery)	50% co-insurance/prescription (retail), Not Covered (home delivery)	Coverage is limited up to a 31 -day supply (retail) and up to a 90 -day supply (home delivery)
	Preferred brand drugs	$40 co-pay/prescription (retail), $80 co-pay/prescription (home delivery)	50% co-insurance/prescription (retail), Not Covered (home delivery)	Coverage is limited up to a 31 -day supply (retail) and up to a 90 -day supply (home delivery)
	Non-preferred brand drugs	50% co-insurance/prescription with $100 minimum/ $150 maximum (retail), 50% co-insurance/prescription with $200 minimum/ $300 maximum (home delivery)	50% co-insurance/prescription (retail), Not Covered (home delivery)	Coverage is limited up to a 31 -day supply (retail) and up to a 90 -day supply (home delivery)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Non-Hospital Based** $100 co-pay	40% co-insurance after plan deductible	In-Network Hospital Based or Affiliated is 20% co-insurance after plan deductible
	Physician/surgeon fees	No Charge	40% co-insurance after plan deductible	
If you need immediate medical attention	Emergency room services	$300 co-pay/visit	$300 co-pay/visit	Per visit co-pay is waived if admitted.For sevices rendered at JMH Facilities (Memorial, North & South), $150 co-pay/ visit
	Emergency medical transportation	$50 co-pay	$50 co-pay	----------none----------
	Urgent care	$70 co-pay/visit	$70 co-pay/visit	

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after plan deductible	40% co-insurance after plan deductible	----------none----------
	Physician/surgeon fees	20% co-insurance after plan deductible	40% co-insurance after plan deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/office visit and No Charge/other outpatient services	40% co-insurance after plan deductible	----------none----------
	Mental/Behavioral health inpatient services	20% co-insurance after plan deductible	40% co-insurance after plan deductible	----------none----------
	Substance use disorder outpatient services	$25 co-pay/office visit and No Charge/other outpatient services	40% co-insurance after plan deductible	----------none----------
	Substance use disorder inpatient services	20% co-insurance after plan deductible	40% co-insurance after plan deductible	----------none----------
If you are pregnant	Prenatal and postnatal care	20% co-insurance after plan deductible	40% co-insurance after plan deductible	
	Delivery and all inpatient services	20% co-insurance after plan deductible	40% co-insurance after plan deductible	----------none----------
If you need help recovering or have other special health needs	Home health care	20% co-insurance after plan deductible	40% co-insurance after plan deductible	----------none----------
	Rehabilitation services	**Physical, Speech & Occupational Therapy,** $50 co-pay/visit **Pulmonary & Cardiac Rehabilitation** $70 co-pay/visit	40% co-insurance after plan deductible	Coverage for Rehabilitation, including Cardiac Rehabilitation, services is limited to 40 days annual max for each therapy
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	20% co-insurance after plan deductible	40% co-insurance after plan deductible	Coverage is limited to 90 days annual max
	Durable medical equipment	20% co-insurance after plan deductible	40% co-insurance after plan deductible	----------none----------
	Hospice services	20% co-insurance after plan deductible	40% co-insurance after plan deductible	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If your child needs dental or eye care	Eye Exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

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 eye care (Adult)
- Routine foot care
- 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

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.

----------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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,690
- **Patient pays:** $1,850

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	$500
Co-pays	$110
Co-insurance	$1,210
Limits or exclusions	$30
Total	**$1,850**

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	$1,120
Co-insurance	$0
Limits or exclusions	$320
Total	**$1,440**

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: 39942
Plan Name: OAP 10

Open Access Plus: Miami-Dade County Public Schools

Coverage Period: 01/01/2013 - 12/31/2013

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

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	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**.	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**.
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$2,000** person / **$4,000** family / For out-of-network providers **$6,500** person / **$13,000** family	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.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, co-payments, plan deductibles, penalties for no pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.myCigna.com or call 1-800-806-3052	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**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **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	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	50% co-insurance after plan deductible	In-network convenience care clinic visit- $10 co-pay/visit
	Specialist visit	CCN Specialist: $50 co-pay/visit Non-CCN Specialist: $70 co-pay/visit	50% co-insurance after plan deductible	Contact Cigna for Cigna Care Network specialties information
	Other practitioner office visit	$70 co-pay/visit for chiropractor	50% co-insurance after plan deductible	Coverage for Chiropractic services is limited to 30 days annual max.
	Preventive care/screening/immunization	No charge	Not Covered	Preventative care and immunizations for children through age 15 are covered out-of-network with 50% co-insurance and no deductible. Well Woman exam is covered out-of-network with 50% co-insurance after plan deductible.

Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider	Your Cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	**Xray:** Non-Hospital Based $100 co-pay **Blood Work:** No Charge	50% co-insurance after plan deductible	Xray In-Network Hospital Based or Affiliated is 30% co-insurance after plan deductible
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based $100 co-pay per type of scan/day	50% co-insurance	In-Network Hospital Based or Affiliated is 30% co-insurance after plan deductible
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com	Generic drugs	$15 co-pay/prescription (retail), $30 co-pay/prescription (home delivery)	50% co-insurance/prescription (retail), Not Covered (home delivery	Coverage is limited up to a 31 -day supply (retail) and up to a 90 -day supply (home delivery)
	Preferred brand drugs	$40 co-pay/prescription (retail), $80 co-pay/prescription (home delivery)	50% co-insurance/prescription (retail), Not Covered (home delivery)	Coverage is limited up to a 31 -day supply (retail) and up to a 90 -day supply (home delivery)
	Non-preferred brand drugs	50% co-insurance/prescription with $100 minimum/ $150 maximum (retail), 50% co-insurance/prescription with $200 minimum/ $300 maximum (home delivery)	50% co-insurance/prescription (retail), Not Covered (home delivery)	Coverage is limited up to a 31 -day supply (retail) and up to a 90 -day supply (home delivery)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Non-Hospital Based** $100 co-pay	50% co-insurance after plan deductible	In-Network Hospital Based or Affiliated is 30% co-insurance after plan deductible
	Physician/surgeon fees	No Charge	50% co-insurance after plan deductible	
If you need immediate medical attention	Emergency room services	$300 co-pay/visit	$300 co-pay/visit	Per visit co-pay is waived if admitted.For services rendered at JMH Facilities (Memorial, North & South), $150 co-pay/visit
	Emergency medical transportation	$50 co-pay	$50 co-pay	----------none----------
	Urgent care	$70 co-pay/visit	$70 co-pay/visit	

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance after plan deductible	50% co-insurance after plan deductible	----------none----------
	Physician/surgeon fees	30% co-insurance after plan deductible	50% co-insurance after plan deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/office visit and No Charge/other outpatient services	50% co-insurance after plan deductible	----------none----------
	Mental/Behavioral health inpatient services	30% co-insurance after plan deductible	50% co-insurance after plan deductible	----------none----------
	Substance use disorder outpatient services	$25 co-pay/office visit and No Charge/other outpatient services	50% co-insurance after plan deductible	----------none----------
	Substance use disorder inpatient services	30% co-insurance after plan deductible	50% co-insurance after plan deductible	----------none----------
If you are pregnant	Prenatal and postnatal care	30% co-insurance after plan deductible	50% co-insurance after plan deductible	
	Delivery and all inpatient services	30% co-insurance after plan deductible	50% co-insurance after plan deductible	----------none----------
If you need help recovering or have other special health needs	Home health care	30% co-insurance after plan deductible	50% co-insurance after plan deductible	----------none----------
	Rehabilitation services	**Physical, Speech & Occupational Therapy** $50 co-pay/visit **Pulmonary & Cardiac Rehabilitation** $70 co-pay/visit	50% co-insurance after plan deductible	Coverage for Rehabilitation, including Cardiac Rehabilitation, services is limited to 40 days annual max for each therapy
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	30% co-insurance after plan deductible	50% co-insurance after plan deductible	Coverage is limited to 90 days annual max
	Durable medical equipment	30% co-insurance after plan deductible	50% co-insurance after plan deductible	----------none----------
	Hospice services	30% co-insurance after plan deductible	50% co-insurance after plan deductible	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If your child needs dental or eye care	Eye Exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

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 eye care (Adult)
- Routine foot care
- 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

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.

----------*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.

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	$1,120
Co-insurance	$0
Limits or exclusions	$320
Total	**$1,440**

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: 39946
Plan Name: OAP 20

Dollars & Sense

Six easy ways to decrease your out-of-pocket health care expenses.

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

2. **Go to the Most Appropriate Place for Urgent Care** Emergency Rooms (ER) provide immediate specialized care to people with serious, often life-threatening issues. However, many people often use the ER for conditions that are much less serious. Treatment for non-emergency conditions in an ER costs hundreds of dollars more than treatment at an urgent care center or your doctor's office. If you need care and you're not sure whether you need to go to the ER, call your doctor's office or CIGNA's 24-hour nurse line at 1.800.CIGNA24.

3. **Use Convenience Care Clinics** Convenience Care clinics offer quick and convenient access to affordable care for common medical conditions when you cannot get an immediate appointment with your doctor. They are often located in department stores, grocery stores and pharmacies, and most are open nights and weekends. When your doctor is not available, you can save time and money by using a Convenience Care clinic for minor or routine conditions, instead of going to an ER or urgent care center. To locate Convenience Care clinics near you, check our provider directory on myCIGNA.com or CIGNA.com, or call the customer service number on the back of your CIGNA ID card.

4. **Laboratory and Pathology Tests** Two of the nation's largest laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the CIGNA network. Services at these labs can cost 70-75% less than the same services provided by hospital-based facilities and other laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check our provider directory on myCIGNA.com or CIGNA.com. You can also contact Quest or LabCorp directly by phone or visit their websites:
   - Quest: 800.377.7220 / web: www.questdiagnostics.com
   - LabCorp: 888.522.2677 / web: www.labcorp.com

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

6. **Selecting Where to Go for a Colonoscopy, Endoscopy or Arthroscopy.** When your doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using an independent outpatient surgery center for these procedures instead of a hospital can often save hundreds of dollars. Talk with your doctor about options. For help locating the most appropriate facility, you can use our cost comparison tools on myCIGNA.com or call the customer service number on the back of your CIGNA ID card.

Care Management for Inpatient & Outpatient Services

All of the advantages. None of the hassle.

CIGNA Care Management is designed to make sure you receive 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 quality care is proven – our customers report a 97 percent overall satisfaction rating with their care 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.

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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:

INPATIENT SERVICES	OUTPATIENT SERVICES

• All inpatient admissions and non-obstetric observation stays such as:
  • Acute hospitals
  • Skilled nursing facilities
  • Rehabilitation facilities
  • Long-term acute care facilities
  • Hospice care
  • Transfers between in-patient facilities
• Experimental and investigational procedures
• Cosmetic procedures
• Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section)
	• Outpatient surgery
	• High-tech radiology (MRI, CAT Scans, PET Scans)
	• Injectible drugs (other than self-injectibles)
	• Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)
	• Home health care/home infusion therapy
	• Dialysis (to direct to a participating facility)
	• External prosthetic appliances
	• Biofeedback
	• Speech therapy
	• Cosmetic or reconstructive procedures
	• Infertility treatment

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.

Easy to register. Easy to use.

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.

Cigna.

Guide to Your Explanation of Benefits

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

Page 1

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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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 January 17, 2011

for services provided by LESLIE CHO, MD

Amount billed	$189.00	This was the amount that was billed for your visit on 01/17/2010.
Discount	$70.05	**You saved $70.05.** CIGNA negotiates discounts with health care professionals and facilities to help you save money.
Amount not covered	$0.00	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.
What my CIGNA plan paid	$107.06	CIGNA paid $107.06 to LESLIE CHO MD on 01/30/2010.
What I owe	**$11.89**	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	**94%**	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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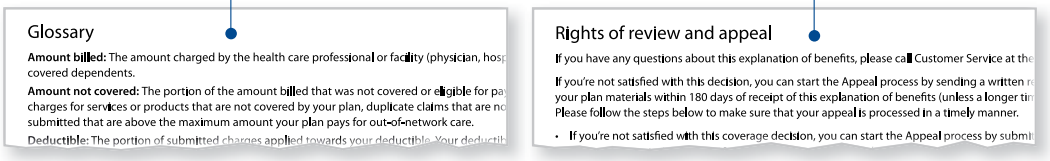
Guide to Your Explanation of Benefits

Page 2

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

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



Glossary

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

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

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

Rights of review and appeal

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

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

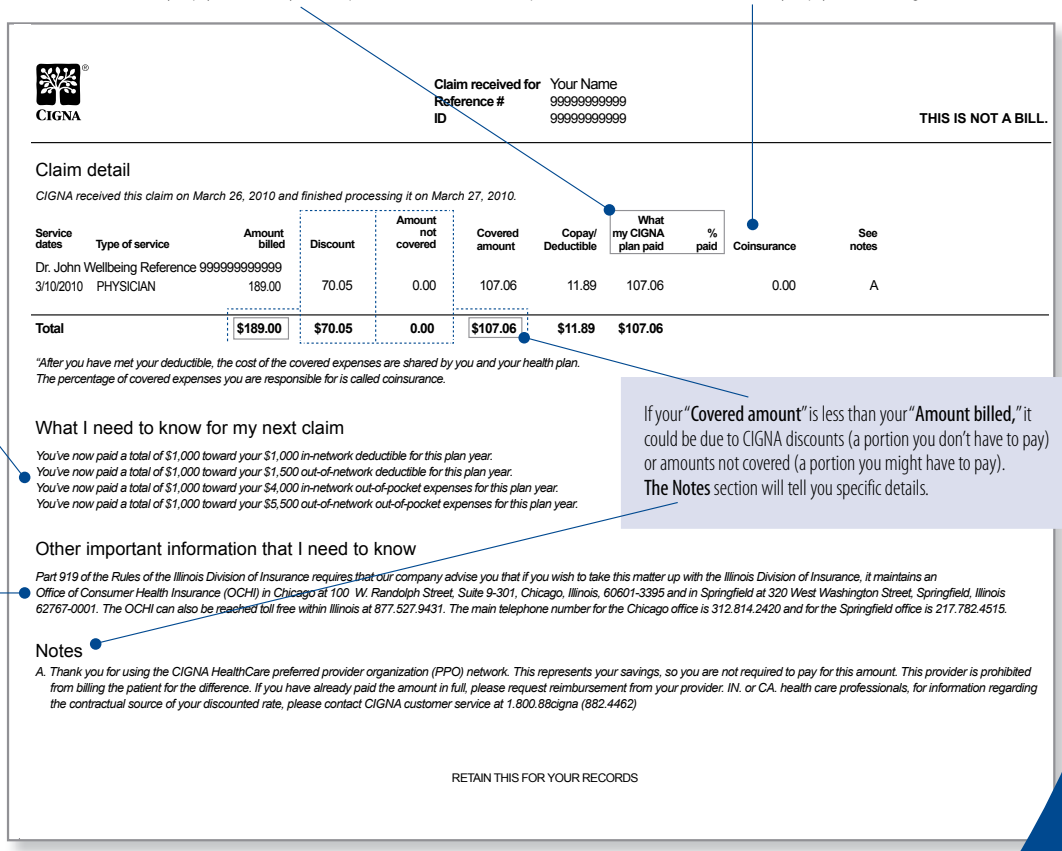
- If you're not satisfied with this coverage decision, you can start the Appeal process by submi

Page 3

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

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

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



CIGNA

Claim received for Your Name
Reference # 99999999999
ID 99999999999

THIS IS NOT A BILL.

Claim detail

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

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/ Deductible	What my CIGNA plan paid	% paid	Coinsurance	See notes
Dr. John Wellbeing Reference 999999999999										
3/10/2010	PHYSICIAN	189.00	70.05	0.00	107.06	11.89	107.06		0.00	A
Total		**$189.00**	**$70.05**	**0.00**	**$107.06**	**$11.89**	**$107.06**			

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

What I need to know for my next claim

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

Other important information that I need to know

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

Notes

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

RETAIN THIS FOR YOUR RECORDS

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.

CIGNA LIFESOURCE Transplant Network®

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

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

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

Benefits from the Comprehensive Transplant Case Management Unit include:

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

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

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

Respected hospitals and medical centers throughout the United States.

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

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

Healthcare Benefits (Pharmacy Benefit)

Spend Less On Prescription Medications

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

Know Your Pharmacy Benefit

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

- Go to **myCigna.com** after January 1, 2013 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 copay—and include commonly prescribed generic medications for several conditions such as asthma, anxiety, high blood pressure and infection (antibiotics).

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

Ask About Over-the-Counter (OTC) Alternatives

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

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

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

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
- 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-daay 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, 850mg and 1,000mg)

Alternative Pharmacy Options Outside Your Healthcare Plan

Value-Priced Medication List

In addition to the discounts on thousands of brand-name and most other generic medications that Walgreens Prescription Savings Club members enjoy, club members may now receive even deeper discounts on these 700+ generics through a three-tier formulary.*

The price for a generic drug is based on its tier and whether it is a 30-day or 90-day supply:

- 30-day-supply drugs cost $5 (tier 1), $10 (tier 2) or $15 (tier 3)
- 90-day-supply drugs cost $10 (tier 1), $20 (tier 2) or $30 (tier 3)

VALUE GENERICS

Antifungal

Drug Name	Tier	Quantity 30	90
FLUCONAZOLE 50MG TAB	3	20	60
FLUCONAZOLE 150MG TAB	2	1	3
TERBINAFINE 250MG TAB	2	30	90

Antimalaria

Drug Name	Tier	Quantity 30	90
MEFLOQUINE HCL 250MG TAB	3	5	15

Antiviral

Drug Name	Tier	Quantity 30	90
ACYCLOVIR 200MG TAB	2	60	180

Arthritis or Pain

Drug Name	Tier	Quantity 30	90
BACLOFEN 10MG TAB	2	90	270
BACLOFEN 20MG TAB	3	90	270
CHLORZOXAZONE 500MG TAB	3	60	180
CYCLOBENZAPRINE 5MG TAB	2	30	90
CYCLOBENZAPRINE 10MG TAB	2	30	90
DICLOFENAC POTASSIUM 50MG TAB	3	60	180
DICLOFENAC SODIUM 25MG TAB	3	60	180
DICLOFENAC SODIUM 50MG TAB	3	60	180
DICLOFENAC SODIUM 75MG EC TAB	3	60	180
DICLOFENAC SODIUM 100MG ER TAB	3	30	90
ETODOLAC 300MG CAP	3	60	180
ETODOLAC ER 400 TAB	3	30	90
FLURBIPROFEN 50MG TAB	3	60	180
FLURBIPROFEN 100MG TAB	3	60	180
IBUPROFEN 100MG/5ML ORAL SUSP	2	120	360
IBUPROFEN 400MG TAB	2	90	270
IBUPROFEN 600MG TAB	2	60	180
IBUPROFEN 800MG TAB	2	60	180
INDOMETHACIN 25MG CAP	2	60	180
INDOMETHACIN 50MG CAP	1	30	90
KETOPROFEN 50MG CAP	3	90	270
KETOPROFEN 75MG CAP	3	60	180
KETOROLAC 10MG TAB	2	15	45
KETOROLAC 30MG/ML INJ, 2ML	3	15	45
LEFLUNOMIDE 10MG TAB	3	30	90
MELOXICAM 7.5MG TAB	2	30	90
MELOXICAM 15MG TAB	2	30	90
NABUMETONE 500MG TAB	3	60	180
NAPROXEN 250MG TAB	1	60	180
NAPROXEN 375MG TAB	1	60	180
NAPROXEN 500MG TAB	1	60	180
NAPROXEN 375MG DR TAB	3	60	180

Arthritis or Pain (cont.)

Drug Name	Tier	Quantity 30	90
NAPROXEN DR 500MG TAB	3	60	180
NAPROXEN SODIUM 275MG TAB	1	30	90
NAPROXEN SODIUM 550MG TAB	3	30	90
OXAPROZIN 600MG TAB	3	60	180
SULINDAC 150MG TAB	3	60	180
TIZANIDINE 2MG TAB	3	60	180
TRAMADOL 50MG TAB	3	120	360

Asthma

Drug Name	Tier	Quantity 30	90
ALBUTEROL 0.083% INH SOLN 25X3ML	2	75	225
ALBUTEROL 0.5% INH SOL 20ML	2	20	60
ALBUTEROL SULFATE 2MG TAB	2	60	180
ALBUTEROL SULFATE 4MG TAB	3	60	180
ALBUTEROL SULF INH SOLN 1.25MG/3ML	3	90	270
ALBUTEROL SULFATE SYRUP (2MG/5ML)	1	120	360
AMINOPHYLLINE 100MG TAB	2	60	180
AMINOPHYLLINE 200MG TAB	2	60	180
DYPHYLLINE-GG 100-100 ELIXIR	2	240	720
DYPHYLLIN-GG TAB	3	30	90
IPRATROPIUM INHAL SOLN 60 X 2.5ML	2	75	225
TERBUTALINE 2.5MG TAB	3	30	90
TERBUTALINE 5MG TAB	3	30	90
THEOPHYLLINE 200MG CR TAB	3	60	180
THEOPHYLLINE 300MG CR TAB	3	60	180
THEOPHYLLINE 100MG ER TAB	2	60	180
THEOPHYLLINE 200MG ER TAB	3	60	180

Blood Pressure/Heart Health

Drug Name	Tier	Quantity 30	90
AMILORIDE 5MG / HCTZ 50MG TAB	2	30	90
AMIODARONE 200MG TAB	1	30	90
AMLODIPINE BESYLATE 2.5MG TAB	2	30	90
AMLODIPINE BESYLATE 5MG TAB	2	30	90
AMLODIPINE BESYLATE 10MG TAB	2	30	90
AMLODIPINE-BENAZ 2.5/10MG CAP	3	30	90
AMLODIPINE-BENAZ 5/10MG CAP	3	30	90
AMLODIPINE-BENAZ 5/20MG CAP	3	30	90
AMLODIPINE-BENAZ 10/20MG CAP	3	30	90
ATENOLOL 100MG TAB	1	30	90
ATENOLOL 100MG/CHLORTHAL 25MG TAB	2	30	90
ATENOLOL 25MG TAB	2	60	180
ATENOLOL 50MG TAB	2	60	180
ATENOLOL/CHLORTHALIDONE 50/25 TAB	2	30	90
BENAZEPRIL 5MG TAB	2	30	90
BENAZEPRIL 10MG TAB	2	30	90
BENAZEPRIL 20MG TAB	2	30	90
BENAZEPRIL 40MG TAB	2	30	90
BENAZEPRIL/HCTZ 10/12.5MG TAB	2	30	90
BENAZEPRIL/HCTZ 20/12.5MG TAB	2	30	90

Blood Pressure/Heart Health (cont.)

Drug Name	Tier	Quantity 30	90
BENAZEPRIL/HCTZ 20/25MG TAB	2	30	90
BISOPROLOL FUMARATE 5MG TAB	2	30	90
BISOPROLOL/HCTZ 2.5MG/6.25MG TAB	2	30	90
BISOPROLOL/HCTZ 5MG/6.25MG TAB	2	30	90
BISOPROLOL/HCTZ 10MG/6.25MG TAB	2	30	90
BUMETANIDE 0.5MG TAB	2	30	90
BUMETANIDE 1MG TAB	2	30	90
BUMETANIDE 2MG TAB	3	30	90
CAPTOPRIL 12.5MG TAB	2	60	180
CAPTOPRIL 25MG TAB	2	60	180
CAPTOPRIL 50MG TAB	2	60	180
CAPTOPRIL 100MG TAB	2	60	180
CAPTOPRIL/HCTZ 25/15 TAB	3	60	180
CAPTOPRIL/HCTZ 25/25 TAB	3	60	180
CARTIA 120MG XT CAP	3	30	90
CARVEDILOL 3.125MG TAB	2	60	180
CARVEDILOL 6.25MG TAB	2	60	180
CARVEDILOL 12.5MG TAB	2	60	180
CARVEDILOL 25MG TAB	2	60	180
CHLOROTHIAZIDE 250MG TAB	2	60	180
CHLOROTHIAZIDE 500MG TAB	3	60	180
CHLORTHALIDONE 25MG TAB	3	30	90
CHLORTHALIDONE 50MG TAB	3	30	90
CILOSTAZOL 50MG TAB	3	60	180
CILOSTAZOL 100MG TAB	3	60	180
CLONIDINE 0.1MG TAB	2	60	180
CLONIDINE 0.2MG TAB	2	60	180
CLONIDINE 0.3MG TAB	2	60	180
DIGOXIN 0.125MG TAB	1	30	90
DIGOXIN 0.25MG TAB	1	30	90
DILTIAZEM 30MG TAB	2	60	180
DILTIAZEM 60MG TAB	2	60	180
DILTIAZEM 90MG TAB	2	60	180
DILTIAZEM 120MG TAB	2	30	90
DILTIAZEM ER 120MG CAP (XR-24HR)	3	30	90
DIPYRIDAMOLE 25MG TAB	3	60	180
DIPYRIDAMOLE 50MG TAB	3	60	180
DIPYRIDAMOLE 75MG TAB	3	60	180
DOXAZOSIN 1MG TAB	2	30	90
DOXAZOSIN 2MG TAB	2	30	90
DOXAZOSIN 4MG TAB	2	30	90
DOXAZOSIN 8MG TAB	2	30	90
ENALAPRIL 2.5MG TAB	1	60	180
ENALAPRIL 5MG TAB	1	60	180
ENALAPRIL 10MG TAB	1	60	180
ENALAPRIL 20MG TAB	1	60	180
ENALAPRIL-HCTZ 5-12.5MG TAB	1	60	180
ENALAPRIL-HCTZ 10-25MG TAB	1	30	90
FOSINOPRIL 10MG TAB	2	30	90
FOSINOPRIL 20MG TAB	2	30	90
FOSINOPRIL 40MG TAB	2	30	90
FUROSEMIDE 8MG/ML SOLN	3	120	360

Alternative Pharmacy Options Outside Your Healthcare Plan

Valued–Priced Medication List (cont.)

Blood Pressure/Heart Health (cont.)

Drug Name	Tier	Quantity 30	90
FUROSEMIDE 10MG/ML ORAL SOLN 60ML	3	90	270
FUROSEMIDE 20MG TAB	1	60	180
FUROSEMIDE 40MG TAB	1	60	180
FUROSEMIDE 80MG TAB	1	30	90
GUANFACINE 1MG TAB	2	30	90
GUANFACINE 2MG TAB	2	30	90
HYDRALAZINE 10MG TAB	1	60	180
HYDRALAZINE 25MG TAB	2	60	180
HYDRALAZINE 50MG TAB	3	90	270
HYDROCHLOROTHIAZIDE 12.5MG CAP	2	30	90
HYDROCHLOROTHIAZIDE 12.5MG TAB	3	30	90
HYDROCHLOROTHIAZIDE 25MG TAB	1	30	90
HYDROCHLOROTHIAZIDE 50MG TAB	1	30	90
INDAPAMIDE 1.25MG TAB	2	30	90
INDAPAMIDE 2.5MG TAB	2	30	90
ISOSORBIDE DINITRATE 5MG ORAL TAB	1	90	270
ISOSORBIDE DINITRATE 10MG ORAL TAB	2	90	270
ISOSORBIDE DINITRATE 20MG ORAL TAB	2	90	270
ISOSORBIDE DINITRATE 30MG ORAL TAB	3	60	180
ISOSORBIDE DINITRATE 2.5MG SL TAB	2	30	90
ISOSORBIDE DINITRATE 5MG SUBL TAB	3	120	360
ISOSORBIDE MONONITRATE 10MG TAB	3	60	180
ISOSORBIDE MONONITRATE 20MG TAB	3	60	180
ISOSORBIDE MONONITRATE 30MG ER TAB	2	30	90
ISOSORBIDE MONONITRATE 60MG ER TAB	2	30	90
ISOSORBIDE MONONITRATE 120MG ER TAB	3	30	90
LISINOPRIL 2.5MG TAB	2	30	90
LISINOPRIL 5MG TAB	2	30	90
LISINOPRIL 10MG TAB	1	30	90
LISINOPRIL 20MG TAB	1	30	90
LISINOPRIL 30MG TAB	2	30	90
LISINOPRIL 40MG TAB	2	30	90
LISINOPRIL-HCTZ 10/12.5MG TAB	2	30	90
LISINOPRIL-HCTZ 20/12.5MG TAB	2	30	90
LISINOPRIL-HCTZ 20/25MG TAB	2	30	90
LOSARTAN/HCTZ 100/12.5MG TAB	3	30	90
METHYLDOPA 250MG TAB	3	60	180
METHYLDOPA 500MG TAB	3	60	180
METOLAZONE 2.5MG TAB	3	30	90
METOLAZONE 5MG TAB	3	30	90
METOLAZONE 10MG TAB	3	30	90
METOPROLOL TARTRATE 25MG TAB	2	60	180
METOPROLOL TARTRATE 50MG TAB	2	60	180
METOPROLOL TARTRATE 100MG TAB	2	60	180
MOEXIPRIL 7.5MG TAB	3	30	90
MOEXIPRIL 15MG TAB	3	30	90
MOEXIPRIL/HCTZ 7.5-12.5MG TAB	3	30	90
MOEXIPRIL/HCTZ 15-12.5MG TAB	3	30	90
MOEXIPRIL/HCTZ 15-25MG TAB	3	30	90
NADOLOL 20MG TAB	2	30	90
NADOLOL 40MG TAB	2	30	90
NADOLOL 80MG TAB	3	30	90
NICARDIPINE 20MG CAP	3	60	180
NITROGLYCERIN 6.5MG SR 100	1	30	90
PENTOXIFYLLINE 400MG ER TAB	3	60	180
PERINDOPRIL 4MG TAB	3	30	90
PRAZOSIN 1MG CAP	1	30	90
PRAZOSIN 2MG CAP	2	60	180
PRAZOSIN HCL 5MG CAP	2	60	180
PROPAFENONE 150MG TAB	3	90	270
PROPRANOLOL 10MG TAB	2	60	180
PROPRANOLOL 20MG TAB	2	60	180
PROPRANOLOL 40MG TAB	2	60	180
PROPRANOLOL 60MG TAB	3	60	180
PROPRANOLOL 80MG TAB	2	60	180
PROPRANOLOL ER 60MG CAP	3	30	90
PROPRANOLOL ER 80MG CAP	3	30	90
PROPRANOLOL ER 120MG CAP	3	30	90
PROPRANOLOL ER 160MG CAP	3	30	90
QUINAPRIL 5MG TAB	2	30	90
QUINAPRIL 10MG TAB	2	30	90
QUINAPRIL 20MG TAB	2	30	90
QUINAPRIL 40MG TAB	2	30	90
QUINAPRIL/HCTZ 10-12.5MG TAB	3	30	90

Blood Pressure/Heart Health (cont.)

Drug Name	Tier	Quantity 30	90
QUINIDINE SULFATE 200MG (3GR) TAB	3	90	270
RAMIPRIL 1.25MG CAP	3	30	90
SOTALOL 120MG TAB	2	60	180
SOTALOL 160MG TAB	3	60	180
SPIRONOLACTONE 25MG TAB	2	30	90
SPIRONOLACTONE 50MG TAB	2	30	90
SPIRONOLACTONE 25MG W/HCTZ 25MG TAB	2	30	90
TERAZOSIN 1MG CAP	2	30	90
TERAZOSIN 2MG CAP	2	30	90
TERAZOSIN 5MG CAP	2	30	90
TERAZOSIN 10MG CAP	2	30	90
TICLOPIDINE 250MG TAB	3	60	180
TORSEMIDE 5MG TAB	3	30	90
TORSEMIDE 10MG TAB	3	30	90
TORSEMIDE 20MG TAB	3	30	90
TORSEMIDE 100MG** TAB	3	30	90
TRANDOLAPRIL 1MG TAB	2	30	90
TRANDOLAPRIL 2MG TAB	1	30	90
TRANDOLAPRIL 4MG TAB	2	30	90
TRIAMTERENE 37.5MG/ HCTZ 25MG CAP	2	30	90
TRIAMTERENE 37.5MG/ HCTZ 25MG TAB	3	30	90
TRIAMTERENE 75MG/ HCTZ 50MG TAB	1	30	90
VERAPAMIL 40MG TAB	3	60	180
VERAPAMIL 80MG TAB	1	30	90
VERAPAMIL 120MG TAB	2	30	90
VERAPAMIL 120MG ER CAP	3	30	90
VERAPAMIL 180MG ER CAP	3	30	90
VERAPAMIL 240MG ER CAP	3	30	90
VERAPAMIL ER 100MG CAP (24 HR)	3	30	90
VERAPAMIL ER 120MG TAB	3	30	90
VERAPAMIL ER 180MG TAB	3	30	90
VERAPAMIL ER 240MG TAB	3	30	90
WARFARIN SOD 1MG TAB	1	30	90
WARFARIN SOD 2.5MG TAB	1	30	90
WARFARIN SOD 2MG TAB	1	30	90
WARFARIN SOD 3MG TAB	1	30	90
WARFARIN SOD 4MG TAB	1	30	90
WARFARIN SOD 5MG TAB	1	30	90
WARFARIN SOD 6MG TAB	1	30	90
WARFARIN SOD 7.5MG TAB	1	30	90
WARFARIN SOD 10MG** TAB	1	30	90

Cholesterol

Drug Name	Tier	Quantity 30	90
FENOFIBRATE 54MG TAB	3	30	90
GEMFIBROZIL 600MG TAB	3	60	180
LOVASTATIN 10MG TAB	1	30	90
LOVASTATIN 20MG TAB	1	30	90
LOVASTATIN 40MG TAB	1	30	90
PRAVASTATIN 10MG TAB	1	30	90
PRAVASTATIN 20MG TAB	1	30	90
PRAVASTATIN 40MG TAB	1	30	90
PRAVASTATIN 80MG TAB	3	30	90
SIMVASTATIN 5MG TAB	2	30	90
SIMVASTATIN 10MG TAB	2	30	90
SIMVASTATIN 20MG TAB	2	30	90
SIMVASTATIN 40MG TAB	3	30	90
SIMVASTATIN 80MG TAB	3	30	90

Cough/Cold/Allergy

Drug Name	Tier	Quantity 30	90
BENZONATATE 100MG CAP	1	30	90
BENZONATATE 200MG CAP	3	30	90
BROMDEX D SYRUP	3	120	360
CETIRIZINE 1MG/ML SYRUP	3	120	360
CETIRIZINE 10MG TAB	2	30	90
CLEMASTINE 2.68MG TAB	3	60	180
CLEMASTINE FUMARATE SYRUP	3	240	720
CYPROHEPTADINE 2MG/5ML SYRUP	3	120	360
CYPROHEPTADINE 4MG TAB	1	60	180
DE-CHLOR DM LIQUID	2	120	360
DE-CHLOR DR SYRUP	2	180	540

Cough/Cold/Allergy (cont.)

Drug Name	Tier	Quantity 30	90
DEHISTINE SYRUP	3	240	720
DIPHENHYDRAMINE 50MG CAP	2	30	90
FLUTICASONE NASAL SP (120INH) 16GM	3	16	48
IPRATROPIUM 0.03% NASAL SPRAY 30ML	3	30	90
IPRATROPIUM 0.06% NASAL SPRAY 15ML	3	15	45
LORATADINE 10MG TAB	1	30	90
NOHIST TAB	3	30	90
ORGAN-I NR 200MG TAB	3	120	360
PBM ALLERGY SYRUP	3	120	360
PHENYLTOLOXAMINE PE CPM SYRUP	2	240	720
PROMETHAZINE 12.5MG SUPP	3	9	27
PROMETHEGAN 25MG SUPP	3	12	36
PROMETHAZINE 6.25MG/5ML SYRUP	2	240	720
PROMETHAZINE 12.5MG TAB	1	12	36
PROMETHAZINE 25MG TAB	1	12	36
PROMETHAZINE 50MG TAB	2	60	180
PROMETHAZINE DM SYRUP	2	180	540
QUARTUSS DM DROPS 30ML	3	30	90
QV-ALLERGY SYRUP	3	240	720
REME TUSSIN DM SYRUP	3	150	450
SILDEC PE-DM SYRUP	1	120	360
SILDEC-PE SYRUP	1	120	360
SUPRESS-DX PED DROPS 30ML	3	30	90
TRIPOHIST LIQUID	3	120	360

Diabetes

Drug Name	Tier	Quantity 30	90
GLIMEPIRIDE 1MG TAB	1	30	90
GLIMEPIRIDE 2MG TAB	1	30	90
GLIMEPIRIDE 4MG TAB	1	30	90
GLIPIZIDE 5MG TAB	1	30	90
GLIPIZIDE 10MG TAB	1	60	180
GLIPIZIDE ER 10MG TAB	3	30	90
GLIPIZIDE XL 2.5MG TAB	3	60	180
GLIPIZIDE XL 5MG TAB	3	30	90
GLIPIZIDE-METFORMIN 2.5MG/500MG TAB	3	90	270
GLIPIZIDE-METFORMIN 5MG/500MG TAB	3	90	270
GLYBURIDE 1.25MG TAB	1	30	90
GLYBURIDE 2.5MG TAB	2	30	90
GLYBURIDE 5MG TAB	2	30	90
GLYBURIDE MICRO 1.5MG TAB	1	30	90
GLYBURIDE MICRO 3MG TAB	1	30	90
GLYBURIDE MICRO 6MG TAB	1	30	90
GLYBURIDE/METFORMIN 1.25/250MG TAB	1	60	180
GLYBURIDE/METFORMIN 2.5/500MG TAB	1	60	180
GLYBURIDE/METFORMIN 5/500MG TAB	3	90	270
METFORMIN 500MG TAB	1	90	270
METFORMIN 850MG TAB	1	90	270
METFORMIN 1000MG TAB	1	90	270
METFORMIN ER 500MG 24HR TAB	1	60	180
METFORMIN ER 750MG 24HR TAB	3	60	180

Ear Care

Drug Name	Tier	Quantity 30	90
ACETIC ACID 2% OTIC SOLN	3	15	45
ANTIPYRINE BENZOCAINE OTIC SOL 15ML	2	15	45

Erectile Dysfunction

Drug Name	Tier	Quantity 30	90
PAPAVERINE 30MG/ML SOL	3	15	45

Eye Care

Drug Name	Tier	Quantity 30	90
BACITRACIN/POLYMYX OPHTHOINT 3.5GM	3	3.5	10.5
CARTEOLOL HCL 1% OPH SOL 5ML	3	5	15
CARTEOLOL HCL 1% OPH SOL 10ML	3	10	30
CARTEOLOL HCL 1% OPH SOL 15ML	3	15	45
CROMOLYN SODIUM 4% OPHTH SOLN 10ML	3	10	30

Alternative Pharmacy Options Outside Your Healthcare Plan

Valued–Priced Medication List (cont.)

3

Eye Care (cont.)

Drug Name	Tier	Quantity 30	90
CYCLOPENTOL 1% OPTH SOLN 15ML	3	15	45
DEXAMETHASONE 0.1% OPHTH SOLN 5ML	3	5	15
DORZOLAMIDE 2% OPHTH SOLN 10ML	3	10	30
ERYTHROMYCIN OPHTH OINT 3.5GM	2	3.5	10.5
GENTAMICIN 0.3% OPHTH SOLN 5ML	2	5	15
KETOROLAC 0.4% OPTH SOLN 5ML	3	5	15
KETOROLAC 0.5% OPHTH SOLN 5ML	3	5	15
LEVOBUNOLOL 0.5% OPTH SOLN 5ML	2	5	15
NEO/POLY/DEX OPHTH SUSP 5ML	2	5	15
NEO/POLY/DEXAMETH OPHTH OINT. 3.5GM	2	3.5	10.5
PILOCARPINE 0.5% OPHTH SOLN	3	15	45
POLYMYXIN-B/TRIMETHOPRIMOPHTH SOLN	2	10	30
PREDNISOLONE AC 1% OPHTH SUSP 5ML	3	5	15
SULFACETAMIDE NA 10% OPH SOL 15ML	2	15	45
TIMOLOL MALEATE .25% OPHTH SOL 5ML	2	5	15
TIMOLOL MALEATE 0.5% OPHTH SOLN 5ML	2	5	15
TOBRAMYCIN 0.3% OPH SOL 5ML	2	5	15
TROPICAMIDE 1% OP SOLN	3	15	45

Gastrointestinal Health

Drug Name	Tier	Quantity 30	90
BELLADONNA ALKALOIDS W/PB TAB	1	60	180
CIMETIDINE 200MG TAB	2	60	180
CIMETIDINE 300MG TAB	2	60	180
CIMETIDINE 400MG TAB	3	60	180
CIMETIDINE ORAL LIQ 300MG/5ML	3	240	720
DICYCLOMINE 10MG CAP	2	90	270
DICYCLOMINE 10MG/5ML SOLN	3	118	354
DICYCLOMINE 20MG TAB	1	60	180
DOC-Q-LACE 100MG CAP	2	60	180
FAMOTIDINE 20MG TAB	2	60	180
FAMOTIDINE 40MG TAB	3	30	90
GENERLAC 10GM/15ML SOLN	2	237	711
HYOSCYAMINE 0.125MG ORAL DIS TAB	3	60	180
HYOSCYAMINE 0.125MG SUBLINGUAL TAB	3	90	270
HYOSCYAMINE SULFATE 0.125MG TAB	3	90	270
LACTULOSE 10GM/15ML SOLN	3	473	1,419
METOCLOPRAMIDE 5MG TAB	2	60	180
METOCLOPRAMIDE 10MG TAB	2	60	180
METOCLOPRAMIDE HCL 5MG/5ML SOLN	1	60	180
NIZATIDINE 150MG CAP	3	60	180
NIZATIDINE 300MG CAP	3	30	90
OMEPRAZOLE 20MG CAP	3	30	90
RANITIDINE 150MG TAB	2	60	180
RANITIDINE 300MG TAB	2	30	90
RANITIDINE 15MG/ML (75MG/5ML) SYRUP	3	120	360
RANITIDINE 300MG CAP	3	30	90

Gout

Drug Name	Tier	Quantity 30	90
ALLOPURINOL 100MG TAB	2	60	180
ALLOPURINOL 300MG TAB	2	60	180

Infections

Drug Name	Tier	Quantity 30	90
AMOX-CLAV 400MG CHEW TAB	3	20	60
AMOX-CLAV 200MG/5ML SUSP 100ML	3	100	300
AMOX-CLAV 400MG/5ML SUSP 100ML	3	100	300
AMOX-CLAV 500MG TAB	3	20	60
AMOX-CLAV ES 600MG/5ML SUSP 125ML	3	125	375
AMOXICILLIN 250MG CAP	1	30	90
AMOXICILLIN 500MG CAP	1	30	90
AMOXICILLIN 125MG CHEWABLE TAB	2	30	90
AMOXICILLIN 250MG CHEW TAB	3	40	120
AMOXICILLIN 125MG/5ML SUSP 150ML	2	150	450
AMOXICILLIN 200MG/5ML SUSP 100ML	1	100	300
AMOXICILLIN 250MG/5ML SUSP 150ML	1	150	450
AMOXICILLIN 400MG/5ML SUSP 75ML	1	75	225
AMOXICILLIN 500MG TAB	3	30	90
AMOXICILLIN 875MG TAB	3	20	60

Infections (cont.)

Drug Name	Tier	Quantity 30	90
AMPICILLIN 250MG CAP	2	40	120
AMPICILLIN 500MG CAP	3	60	180
CEFACLOR 250MG CAP	3	30	90
CEFADROXIL 500MG CAP	3	20	60
CEFDINIR 125MG/5ML SUSPENSION 60ML	3	60	180
CEFDINIR 250MG/5ML SUSPENSION 60ML	3	60	180
CEFUROXIME 250MG TAB	3	20	60
CEPHALEXIN 125MG/5ML SUSP 200ML	3	200	600
CEPHALEXIN 250MG/5ML SUSP 200ML	1	100	300
CEPHALEXIN 250MG CAP	1	28	84
CEPHALEXIN 500MG CAP	1	30	90
CIPROFLOXACIN 250MG TAB	1	14	42
CIPROFLOXACIN 500MG TAB	1	20	60
CIPROFLOXACIN 750MG TAB	3	20	60
CLINDAMYCIN 150MG CAP	3	30	90
CLINDAMYCIN 300MG CAP	3	28	84
DICLOXACILLIN 250MG CAP	3	40	120
DOXYCYCLINE HYCLATE 50MG CAP	1	30	90
DOXYCYCLINE HYCLATE 100MG CAP	1	20	60
DOXYCYCLINE HYCLATE 20MG TAB	3	60	180
DOXYCYCLINE HYCLATE 100MG TAB	3	30	90
DOXYCYCLINE MONOHYDRATE 50MG TAB	3	30	90
DOXYCYCLINE MONOHYDRATE 100MG TAB	3	30	90
ERYTHROMYCIN ES 200MG/5ML SUSP	1	120	360
METRONIDAZOLE 250MG TAB	2	28	84
METRONIDAZOLE 500MG TAB	3	14	42
MINOCYCLINE 50MG CAP	3	60	180
MINOCYCLINE 75MG CAP	3	60	180
MINOCYCLINE 100MG CAP	3	30	90
PENICILLIN VK 125MG/5ML SOLN 200ML	1	200	600
PENICILLIN VK 250MG/5ML SOLN 100ML	1	100	300
PENICILLIN VK 250MG TAB	1	30	90
PENICILLIN VK 500MG TAB	1	20	60
SMZ/TMP REGULAR STRENGTH TAB	1	28	84
SULFAMETH/TRIMETHOPRIM 800/160 TAB	2	28	84
SULFAMETH-TRIMETH SUSP	1	150	450
TETRACYCLINE 250MG CAP	2	60	180
TETRACYCLINE 500MG CAP	2	60	180
TRIMETHOPRIM 100MG TAB	3	30	90

Medical Devices

Drug Name	Tier	Quantity 30	90
PROCHAMBER AERO SPACER	3	1	3

Mental Health

Drug Name	Tier	Quantity 30	90
AMANTADINE 50MG/5ML SYRUP	3	360	1080
AMITRIPTYLINE 10MG TAB	1	30	90
AMITRIPTYLINE 25MG TAB	1	30	90
AMITRIPTYLINE 50MG TAB	1	30	90
AMITRIPTYLINE 75MG TAB	2	30	90
AMITRIPTYLINE 100MG** TAB	1	30	90
AMITRIPTYLINE 150MG TAB	2	30	90
BENZTROPINE 0.5MG TAB	1	30	90
BENZTROPINE 1MG TAB	3	60	180
BENZTROPINE 2MG TAB	2	30	90
BUSPIRONE 5MG TAB	2	60	180
BUSPIRONE 10MG TAB	2	60	180
BUSPIRONE 15MG TAB	3	60	180
CARBAMAZEPINE 100MG CHEWABLE TAB	3	120	360
CARBAMAZEPINE 200MG TAB	2	100	300
CITALOPRAM 10MG TAB	2	30	90
CITALOPRAM 20MG TAB	2	30	90
CITALOPRAM 40MG TAB	2	30	90
CLOMIPRAMINE 25MG CAP	3	60	180
CLOMIPRAMINE 50MG CAP	3	60	180
DIVALPROEX DR 125MG TAB	3	90	270
DOXEPIN 10MG CAP	1	30	90
DOXEPIN 25MG CAP	2	30	90
DOXEPIN 50MG CAP	2	30	90
DOXEPIN 75MG CAP	3	30	90

Mental Health (cont.)

Drug Name	Tier	Quantity 30	90
DOXEPIN 100MG** CAP	3	30	90
DOXEPIN HCL 10MG/ML CONC 118ML	3	90	270
FLUOXETINE 10MG CAP	1	30	90
FLUOXETINE 20MG CAP	1	30	90
FLUOXETINE 40MG CAP	1	30	90
FLUOXETINE 10MG TAB	1	30	90
FLUOXETINE 20MG TAB	1	30	90
FLUOXETINE 20MG/5ML LIQUID	3	150	450
FLUPHENAZINE 1MG TAB	2	60	180
FLUPHENAZINE 2.5MG TAB	3	30	90
FLUPHENAZINE 5MG TAB	3	30	90
FLUVOXAMINE 25MG TAB	3	30	90
FLUVOXAMINE 100MG TAB	3	60	180
GABAPENTIN 100MG CAP	2	90	270
GABAPENTIN 300MG CAP	3	90	270
GABAPENTIN 400MG CAP	3	90	270
GABAPENTIN 250MG/5ML SOLN	3	236	708
HALOPERIDOL 0.5MG TAB	2	60	180
HALOPERIDOL 1MG TAB	1	30	90
HALOPERIDOL 2MG TAB	2	30	90
HALOPERIDOL 2MG/ML CONCENTRATE	3	135	405
HALOPERIDOL 5MG** TAB	2	30	90
HYDROXYZINE 10MG/5ML SYRUP	3	240	720
HYDROXYZINE HCL 10MG TAB	3	60	180
HYDROXYZINE PAMOATE 25MG CAP	3	90	270
IMIPRAMINE 10MG TAB	3	60	180
IMIPRAMINE 25MG TAB	3	60	180
IMIPRAMINE 50MG TAB	3	30	90
LAMOTRIGINE 5MG CHEWABLE TAB	3	150	450
LAMOTRIGINE 25MG CHEWABLE TAB	3	180	540
LITHIUM CARBONATE 150MG CAP	3	60	180
LITHIUM CARBONATE 300MG CAP	2	90	270
LITHIUM CARBONATE 300MG TAB	3	60	180
LITHIUM CARBONATE 600MG CAP	3	60	180
LITHIUM CARBONATE ER 450MG TAB	3	60	180
MIRTAZAPINE 15MG ORAL DSNTGRT TAB	3	30	90
MIRTAZAPINE 30MG ORAL DSNTGRT TAB	3	30	90
MIRTAZAPINE 7.5MG TAB	3	30	90
MIRTAZAPINE 15MG TAB	1	30	90
MIRTAZAPINE 30MG TAB	3	30	90
NORTRIPTYLINE 10MG CAP	2	30	90
NORTRIPTYLINE 25MG CAP	2	30	90
NORTRIPTYLINE 50MG CAP	3	60	180
NORTRIPTYLINE 75MG CAP	3	30	90
OXCARBAZEPINE 150MG TAB	3	90	270
PAROXETINE 10MG TAB	2	30	90
PAROXETINE 20MG TAB	2	30	90
PAROXETINE 30MG TAB	3	30	90
PRAMIPEXOLE 0.125MG TAB	3	30	90
PRAMIPEXOLE 0.25MG TAB	3	30	90
PRAMIPEXOLE 0.5MG TAB	3	60	180
PRAMIPEXOLE 1.5MG TAB	3	60	180
PRIMIDONE 50MG TAB	3	60	180
PROCHLORPERAZINE 5MG TAB	2	30	90
PROCHLORPERAZINE 10MG TAB	2	30	90
RISPERIDONE 0.25MG TAB	3	60	180
RISPERIDONE ODT 0.5MG TAB	3	60	180
RISPERIDONE ODT 1MG TAB	3	60	180
RISPERIDONE ODT 2MG TAB	3	30	90
ROPINIROLE 0.25MG TAB	3	60	180
SERTRALINE 25MG TAB	2	30	90
SERTRALINE 50MG TAB	3	30	90
SERTRALINE 100MG TAB	3	30	90
THIORIDAZINE 10MG TAB	2	60	180
THIORIDAZINE 25MG TAB	2	30	90
THIORIDAZINE 50MG TAB	2	30	90
THIOTHIXENE 1MG CAP	2	60	180
THIOTHIXENE 2MG CAP	3	60	180
TRAZODONE 50MG TAB	2	30	90
TRAZODONE 100MG TAB	1	30	90
TRAZODONE 150MG TAB	2	30	90
TRIFLUOPERAZINE 1MG TAB	3	60	180
TRIFLUOPERAZINE 2MG TAB	3	60	180
TRIHEXYPHENIDYL 2MG TAB	2	60	180
TRIHEXYPHENIDYL 5MG TAB	3	90	270

Alternative Pharmacy Options Outside Your Healthcare Plan

Valued–Priced Medication List (cont.)

Mental Health (cont.)

Drug Name	Tier	Quantity 30	90
VALPROIC ACID 250MG/5ML SYRUP	3	540	1620
VENLAFAXINE 25MG TAB	3	60	180
VENLAFAXINE 37.5MG TAB	3	60	180
VENLAFAXINE 50MG TAB	3	60	180
VENLAFAXINE 75MG TAB	3	60	180
VENLAFAXINE 100MG TAB	3	60	180
ZONISAMIDE 25MG CAP	3	90	270
ZONISAMIDE 50MG CAP	3	90	270

Mouth/Throat/Dental

Drug Name	Tier	Quantity 30	90
CHLORHEXIDINE ORAL RINSE 473ML	2	473	1419
LIDOCAINE VISCOUS 2% ORAL SOL 100ML	2	100	300
PILOCARPINE 5MG TAB	3	90	270
SF 5000 PLUS 1.1% CREAM 51GM	3	60	180
STANNOUS FLUORIDE 0.63% RINSE	3	300	900

Skin Conditions

Drug Name	Tier	Quantity 30	90
AMMONIUM LACTATE 12% CREAM 2X140GM	3	280	840
BENZOYL PEROXIDE 10% WASH 227GM	3	227	681
BENZOYL PEROXIDE 10% WSH LIQ 148GM	3	148	444
BENZOYL PEROXIDE 2.5% AQ GEL 60GM	3	60	180
BENZOYL PEROXIDE 5% AQ GEL 60GM	3	60	180
BENZOYL PEROXIDE 5% WASH227GM	3	227	681
BETAMETHASONE VAL 0.1% CRM 15GM	3	15	45
CICLOPIROX 8% TOPICAL SOLN 6.6ML	3	6.6	19.8
CICLOPIROX TOPICAL SUSPENSION 30ML	3	30	90
CICLOPIROX TOPICAL SUSPENSION 60ML	3	60	180
CLINDAMYCIN 1% GEL 60GM	3	60	180
CLINDAMYCIN 1% TOPICAL SOLN 60ML	3	60	180
CLOTRIMAZOLE 1% CREAM 30GM	3	30	90
CLOTRIMAZOLE 1% SOLN 30ML	3	30	90
DESONIDE 0.05% OINT 15GM	3	15	45
ERYTHROMYCIN 2% GEL 30GM	3	30	90
ERYTHROMYCIN 2% TOPICAL SOLN 60ML	2	60	180
FLUOCINONIDE 0.05% CREAM 30GM	2	30	90
FLUOCINONIDE -E 0.05% CREAM 15GM	2	15	45
FLUOCINONIDE -E 0.05% CREAM 30GM	3	30	90
FLUOCINONIDE -E 0.05% CREAM 60GM	3	60	180
HALOBETASOL 0.05% OINT 50GM	3	50	150
HYDROCORTISONE 1% CREAM 28.35GM	2	28.35	85.05
HYDROCORTISONE 1% OINT 28.35GM	2	28.35	85.05
HYDROCORTISONE 2.5% CREAM 30GM	2	30	90
HYDROCORTISONE 2.5% OINT 28.35GM	3	60	180
HYDROCORTISONE BUT 0.1% OINT 15GM	3	15	45
HYPERCARE 20% SOL DAB-O-MATIC 60ML	3	60	180
MELQUIN 3% SOLN 30ML	3	30	90
MOMETASONE 0.1% OINT 15GM	3	15	45
MOMETASONE 0.1% OINT 45GM	3	45	135
MOMETASONE 0.1% TOPICAL SOLN 30ML	3	30	90
MOMETASONE 0.1% TOPICAL SOLN 60ML	3	60	180
NYSTATIN OINT 15GM	3	15	45
SALICYLIC AC 6% SHAMPOO 177ML	3	177	531
SELENIUM SULFIDE 2.5% SHAMPOO(LOTN)	2	118	354
TRIAMCINOLONE 0.025% CREAM 454GM	1	15	45
TRIAMCINOLONE 0.5% CREAM 15GM	2	15	45
TRIAMCINOLONE 0.1% CREAM 80GM	2	80	240
TRIAMCINOLONE 0.1% OINT 80GM	3	80	240
UREA 40% LOTION 236.6ML	3	236.6	709.8
UREA 50% NAIL GEL 18ML	3	18	54

Thyroid Conditions

Drug Name	Tier	Quantity 30	90
LEVOTHROID 0.1MG TAB	2	30	90
LEVOTHYROXINE 0.025MG (25MCG) TAB	2	30	90
LEVOTHYROXINE 0.05MG (50MCG) TAB	2	30	90
LEVOTHYROXINE 0.075MG (75MCG) TAB	2	30	90
LEVOTHYROXINE 0.088MG (88MCG) TAB	2	30	90
LEVOTHYROXINE 0.112MG (112MCG) TAB	2	30	90
LEVOTHYROXINE 0.125MG (125MCG) TAB	2	30	90
LEVOTHYROXINE 0.137MG (137MCG) TAB	2	30	90
LEVOTHYROXINE 0.150MG (150MCG) TAB	2	30	90
LEVOTHYROXINE 0.175MG (175MCG)TAB	2	30	90
LEVOTHYROXINE 0.2MG(200MCG) TAB	2	30	90
LEVOTHYROXINE 0.3MG (300MCG) TAB	2	30	90
METHIMAZOLE 5MG TAB	2	30	90
METHIMAZOLE 10MG TAB	3	30	90
NATURE-THROID 0.5GR (32.5MG) TAB	2	60	180

Urinary Health

Drug Name	Tier	Quantity 30	90
BETHANECHOL 5MG TAB	3	60	180
BETHANECHOL 10MG TAB	3	60	180
BETHANECHOL 25MG TAB	3	90	270
BETHANECHOL 50MG TAB	3	90	270
OXYBUTYNIN 5MG TAB	2	60	180
OXYBUTYNIN 5MG/5ML SYRUP	3	240	720
OXYBUTYNIN ER 5MG TAB	3	30	90
OXYBUTYNIN ER 10MG TAB	3	30	90
OXYBUTYNIN ER 15MG TAB	3	30	90

Vitamins and Nutritional Health

Drug Name	Tier	Quantity 30	90
CYANOCOBALAMIN 1000MCG/ML INJ, 1ML	1	3	9
FABB TAB	3	30	90
FE C PLUS TAB	3	30	90
FEROTRIN CAP	3	60	180
FERREX 150 FORTE CAP	2	45	135
FLUORIDE 0.25MG F CHEWABLE TAB	2	120	360
FLUORIDE 0.5MG F CHEWABLE TAB	1	30	90
FLUORIDE 1.0MG F CHEWABLE TAB	2	30	90
FOLBECAL TAB	3	30	90
FOLBEE PLUS TAB	3	30	90
FOLBEE TAB	3	30	90
FOLIC ACID 1MG TAB	1	30	90
HEMATINIC/ FA TAB	2	30	90
HEMATINIC PLUS TAB 10 X 10	3	30	90
KLOR-CON 10MEQ TAB	3	30	90
MULTIGEN FOLIC TAB	3	30	90
MULTIGEN TAB	3	30	90
MULTIVIT/F 0.25MG CHEWABLE TAB	2	30	90
MULTI-VIT/FL 0.25MG DROPS 50ML	3	50	150
MULTI-VITA-F 0.5MG CHEW TAB	1	30	90
MULTI-VIT/FLUORIDE 1MG CHEW TAB	2	30	90
MULTIVITAMIN W/FL .5MG/ML ORAL DROP	2	50	150
MULTIVITAMINS W/ FL 1.0MG CHEW TAB	3	30	90
MULTIVITS W/FL 1MG & IRON CHEW TAB	1	30	90
NATALCARE PLUS TAB (1MG FOLIC ACID)	1	30	90
OB-NATAL ONE CAP	3	30	90
PHOSPHA 250 NEUTRAL TAB	3	100	300
POLY-IRON 150 CAP	2	60	180
POLY-IRON 150 FORTE CAP	3	45	135
POT CHLOR 10% LIQ SF (20MEQ/15ML)	2	473	1419
POTASSIUM CHLOR 20% LIQ (40MEQ/15ML)	2	710	2130
POTASSIUM CL 10MEQ ER TAB	3	30	90
PRENAFIRST TAB	3	30	90
PRENATAB FA TAB	2	30	90
PRENATAL - U CAP	3	30	90
PRENATAL 19 CHEWABLE TAB	3	30	90

Vitamins and Nutritional Health (cont.)

Drug Name	Tier	Quantity 30	90
PRENATAL 19 TAB	2	30	90
PRENATAL PLUS TAB	2	30	90
RE DUALVIT F CAP	3	30	90
RE PRENATAL MULTIVIT W/IRON CHEW TB	3	30	90
RENA-VITE RX TAB	1	30	90
RENAL SOFTGEL CAP	2	30	90
SE-NATAL 19 TAB	2	30	90
THEROBEC PLUS TAB	3	30	90
TRI-VIT/FE FL .25MG DROPS 50ML	3	50	150
VINATE AZ TAB	3	30	90
VINATE C TAB	3	30	90
VINATE CARE CHEWABLE TAB	3	30	90
VINATE GT TAB	2	30	90
VITAMIN D 50,000IU CAP	1	4	12

Women's Health

Drug Name	Tier	Quantity 30	90
ALENDRONATE 5MG TAB	3	30	90
ALENDRONATE 10MG TAB	3	30	90
ALENDRONATE 35MG TAB	3	4	12
ALENDRONATE 70MG TAB	3	4	12
ANASTROZOLE 1MG TAB	3	30	90
CLOMIPHENE CITRATE 50MG TAB	2	5	15
EST ESTRGN METHTEST 0.625/1.25MG TB	3	30	90
EST ESTRGN METHTEST 1.25/2.5MG TAB	3	30	90
ESTRADIOL 0.5MG TAB	1	30	90
ESTRADIOL 1MG TAB	1	30	90
ESTRADIOL 2MG TAB	1	30	90
ESTROPIPATE 0.625MG (0.75MG) TAB	2	30	90
ESTROPIPATE 1.5MG (1.25MG) TAB	3	30	90
MEDROXYPROGESTERONE 2.5MG TAB	2	30	90
MEDROXYPROGESTERONE 5MGTAB	1	30	90
MEDROXYPROGESTERONE 10MGTAB	1	10	30
MEGESTROL ACETATE 20MG TAB	2	30	90
TAMOXIFEN 10MG TAB	3	60	180
TAMOXIFEN 20MG TAB	3	30	90

Other

Drug Name	Tier	Quantity 30	90
ANAGRELIDE 0.5MG CAP	3	90	270
ANAGRELIDE 1MG CAP	3	60	180
ANUCORT-HC 25MG RECTAL SUPP 24'S	2	12	36
CYTRA-2 SOLN	3	473	1419
CYTRA-K ORAL SOLN	3	473	1419
DEXAMETHASONE 0.5MG TAB	2	60	180
DEXAMETHASONE 0.75MG TAB	2	12	36
DEXAMETHASONE 1MG TAB	3	30	90
DEXAMETHASONE 1.5MG TAB	3	45	135
DEXAMETHASONE 4MG TAB	2	30	90
FINASTERIDE 5MG TAB	2	30	90
PHENAZOPYRIDINE 100MG TAB	2	30	90
PHENAZOPYRIDINE 200MG TAB	2	30	90
PREDNISOLONE 15MG/5ML SOLN	3	60	180
PREDNISOLONE SOD PHOS 15MG/5ML SOL	2	30	90
PREDNISOLONE SOD PHOS 5MG/5ML SOL	3	120	360
PREDNISONE 1MG TAB	2	90	270
PREDNISONE 2.5MG TAB	2	60	180
PREDNISONE 5MG TAB	2	30	90
PREDNISONE 10MG** TAB	1	30	90
PREDNISONE 20MG TAB	2	30	90
PREDNISONE 5MG TAB PACK 21'S	2	21	63
PREDNISONE 10MG TAB PACK 21'S	2	21	63

Alternative Pharmacy Options Outside Your Healthcare Plan

Valued–Priced Medication List (cont.)

VALUE BRAND-NAME

Insulins

LEVEMIR FLEXPEN	1 BOX	$189.49
LEVEMIR 100 UNITS/ML VIAL	1 VIAL	$105.89
NOVOLIN N 100 UNITS/ML VIAL	1 VIAL	$54.32
NOVOLIN R 100 UNITS/ML VIAL	1 VIAL	$54.32
NOVOLIN 70/30 100 UNIT/ML VIAL	1 VIAL	$54.32
NOVOLOG MIX 70/30 VIAL	1 VIAL	$122.68
NOVOLOG MIX 70/30 FLEXPEN	1 BOX	$238.07
NOVOLOG FLEXPEN	1 BOX	$238.07
NOVOLOG PENFILL 3 ML	1 BOX	$234.85
NOVOLOG 100 UNIT/ML VIAL	1 VIAL	$122.68

Diabetic Supplies

WALGREENS TRUE RESULT METER	1 METER	FREE
WALGREENS TRUE TEST STRIPS 25'S	1 BOX	$17.99
WALGREENS TRUE TEST STRIPS 50'S	1 BOX	$24.99
WALGREENS TRUE TEST STRIPS 100'S	1 BOX	$41.99
BAYER CONTOUR METER	1 METER	FREE
BAYER CONTOUR USB METER	1 METER	FREE
BAYER CONTOUR TEST STRIPS 50'S	1 BOX	$47.99
BAYER CONTOUR TEST STRIPS 100'S	1 BOX	$93.99
BAYER BREEZE 2 METER KIT	1 METER	FREE
BAYER BREEZE 2 TEST DISCS 50'S	1 BOX	$48.99
BAYER BREEZE 2 TEST DISCS 100'S	1 BOX	$93.99

LIFESTYLE MEDICATIONS

Birth Control – Special Price at $12 for 1-month supply

MONONESSA TAB	28
TRINESSA TAB	28

$21.99 for 1-month supply

MICROGESTIN 1.5/30 FE TAB	28
MICROGESTIN 1/20 FE TAB	28

$23.99 for 1-month supply

LOW-OGESTREL TAB	28
NECON 1/35 TAB	28
RECLIPSEN 0.15MG-30MCG TAB	28

$24.99 for 1-month supply

JOLIVETTE 0.35MG TAB	28

$25.99 for 1-month supply

LEVORA 0.15/30 TAB	28
LUTERA TAB	28

Discounted Lifestyle Medications

CIALIS 5MG TAB (QTY 6)	$28.99
CIALIS 10MG TAB (QTY 6)	$165.99
CIALIS 20MG TAB (QTY 6)	$165.99
LATISSE 0.03% OPHTH SOLN	$108.99
PROPECIA 1MG TAB *	
VIAGRA 50MG TAB (QTY 6)	$149.99
VIAGRA 100MG TAB (QTY 6)	$152.99

***PLEASE ASK PHARMACIST FOR DISCOUNTED PRICING**

AVERAGE SAVINGS		
90-day supply of a value-priced generic	Tier 1	$35.68
	Tier 2	$38.56
	Tier 3	$79.13
Commonly prescribed quantities of all other generics		$18.97
Brand-name drugs		$28.58

Membership fee required ($20 individual or $35 family per year). Persons receiving benefits from Medicare, Medicaid or other federal or state healthcare programs are ineligible. Some restrictions apply to 10% bonus. Pet medications are for human-equivalent medications only. Membership may be cancelled within 30 days of issue date for a full refund. If by the end of the 1-year membership, member has not achieved total savings on all eligible Pharmacy and Walgreens Bonus Program items and services purchased with the PSC card that is equal to or greater than membership fee, member is eligible for store credit equal to the difference between membership fee and the member's total savings. For complete terms and conditions, call 866-922-7312 or visit Walgreens.com/rxsavingsclub. Walgreen Co., 200 Wilmot Rd., Deerfield, IL 60015.
THIS PROGRAM DOES NOT CONSTITUTE INSURANCE.
*List of drugs is not all-inclusive. Ask your Walgreens pharmacist if your medication is a value-priced generic.

Alternative Pharmacy Options Outside Your Healthcare Plan

Retail Prescription Program Drug List

Revised 8/1/2012

Price Matters
- Our $4 prescriptions have saved our customers over $3 billion
- The program is available to everyone, no membership required

New Men's Health Category
- More affordable options for men
- $9 Finasteride for 30 tablets

Convenience
- Easy Pay saves you time at the checkout counter
- Ready Reminders send you a free text message when your prescription is ready
- Auto Refill your prescriptions and save time

Free Home Delivery
- Mailed right to your home, no matter where you live
- Free shipping
- Find out more at **Walmart.com/pharmacy**

	$4, 30-day	$10, 90-day
Allergies & Cold and Flu		
Benzonatate 100mg cap	14	42
Loratadine 10mg tab	30	90
Promethazine DM syrup	120ml	360ml
Antibiotic Treatments		
Amoxicillin 125mg/5ml susp (80ml bottle)†	1	3
Amoxicillin 125mg/5ml susp (100ml bottle)†	1	3
Amoxicillin 125mg/5ml susp (150ml bottle)†	1	3
Amoxicillin 200mg/5ml susp (50ml bottle)†	1	3
Amoxicillin 200mg/5ml susp* (75ml bottle)†	1	3
Amoxicillin 200mg/5ml susp* (100ml bottle)†	1	3
Amoxicillin 250mg/5ml susp (80ml bottle)†	1	3
Amoxicillin 250mg/5ml susp (100ml bottle)†	1	3
Amoxicillin 250mg/5ml susp (150ml bottle)†	1	3
Amoxicillin 400mg/5ml susp (50ml bottle)†	1	3
Amoxicillin 400mg/5ml susp* (75ml bottle)†	1	3
Amoxicillin 400mg/5ml susp* (100ml bottle)†	1	3
Amoxicillin 250mg cap	30	90
Amoxicillin 500mg cap	30	90
Cephalexin 250mg cap	28	84
Cephalexin 500mg cap	30	90
Ciprofloxacin 250mg tab	14	42
Ciprofloxacin 500mg tab	20	60
Doxycycline Hyclate 50mg cap	30	90
Doxycycline Hyclate 100mg cap	20	60
Doxycycline Hyclate 100mg tab	20	60
Penicillin VK 250mg tab	28	84
Penicillin VK 125mg/5ml susp (100ml bottle)†	1	3
Penicillin VK 125mg/5ml susp (200ml bottle)†	1	3
Penicillin VK 250mg/5ml susp (100ml bottle)†	1	3
SMZ-TMP 200mg-40mg/5ml susp*	120ml	360ml
SMZ-TMP 400mg-80mg tab	28	84
SMZ-TMP DS 800mg-160mg tab	20	60
Arthritis & Pain		
Allopurinol 100mg tab	30	90
Allopurinol 300mg tab	30	90
Baclofen 10mg tab	30	90
Cyclobenzaprine 5mg tab	30	90
Cyclobenzaprine 10mg tab	30	90
Dexamethasone 0.5mg tab	30	90
Dexamethasone 0.75mg tab	12	36
Dexamethasone 4mg tab	6	18
Diclofenac DR 75mg tab	60	180
Ibuprofen 100mg/5ml susp*	120ml	360ml
Ibuprofen 400mg tab	90	270
Ibuprofen 600mg tab	60	180
Ibuprofen 800mg tab	30	90
Indomethacin 25mg cap*	60	180
Meloxicam 7.5mg tab	30	90
Meloxicam 15mg tab	30	90
Naproxen 375mg tab*	60	180
Naproxen 500mg tab*	60	180
Asthma		
Albuterol 2mg tab	90	270
Albuterol 4mg tab	60	180
Albuterol 2mg/5ml syrup	120ml	360ml
Albuterol 0.5% nebulizer soln* (20ml bottle)†	1	3

Prescription Program includes up to a 30-day supply for $4 and a 90-day supply for $10 of some covered generic drugs at commonly prescribed dosages. Higher dosages cost more. Prices for some drugs covered by the Prescription Program may be higher and may vary in some states. Restrictions apply. See Program Details or your Walmart Pharmacist for details. Free language assistance services available for prescription drug information at Walmart and Sam's Club pharmacies in New York. Contact your Walmart or Sam's Club pharmacy for details.

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Alternative Pharmacy Options Outside Your Healthcare Plan

	$4, 30-day	$10, 90-day
Albuterol 0.083% nebulizer soln* (25x3ml vials)†	1	3
Ipratropium 0.02% nebulizer soln* (25x2.5ml vials)†	1	3

Cholesterol

Lovastatin 10mg tab	30	90
Lovastatin 20mg tab*	30	90
Pravastatin 10mg tab	30	90
Pravastatin 20mg tab	30	90
Pravastatin 40mg tab*	30	90

Diabetes

Glimepiride 1mg tab	30	90
Glimepiride 2mg tab	30	90
Glimepiride 4mg tab	30	90
Glipizide 5mg tab	30	90
Glipizide 10mg tab*	60	180
Glyburide 2.5mg tab	30	90
Glyburide 5mg tab (blue)	30	90
Glyburide 5mg tab (green)	30	90
Glyburide, micronized 3mg tab	30	90
Glyburide, micronized 6mg tab	30	90
Metformin 500mg tab	60	180
Metformin 850mg tab	60	180
Metformin 1000mg tab*	60	180
Metformin 500mg ER tab*	60	180

Ear Health

Antipyrine/Benzocaine otic (15ml bottle)†	1	3

Fungal Infections

Fluconazole 150mg tab	1	3
Nystatin cream* (15gm tube)†	1	3
Nystatin cream* (30gm tube)†	1	3
Terbinafine 250mg tab*	30	90

Gastrointestinal Health

Belladonna Alkaloid/PB tab*	60	180
Cimetidine 800mg tab*	30	90
Cytra2 solution	180ml	540ml
Dicyclomine 10mg cap	90	270
Dicyclomine 20mg tab	60	180
Famotidine 20mg tab	60	180
Lactulose syrup	237ml	711ml
Metoclopramide 10mg tab	60	180
Metoclopramide syrup	60ml	180ml
Promethazine 25mg tab*	12	36
Promethazine plain syrup*	180ml	540ml
Ranitidine 150mg tab	60	180
Ranitidine 300mg tab	30	90

Glaucoma & Eye Care

Atropine Sulfate 1% op. soln* (5ml bottle)†	1	3
Erythromycin op. ointment (3.5gm tube)†*	1	3
Gentamicin 0.3% op. soln (5ml bottle)†	1	3
Levobunolol 0.5% op soln (5ml bottle)†	1	3
Neomycin/Polymyxin/Dexamethasone 0.1% op. ointment (3.5gm tube)†	1	3
Neomycin/Polymyxin/Dexamethasone 0.1% op. susp (5ml bottle)†	1	3
Pilocarpine 1% op. soln (15ml bottle)†	1	3
Pilocarpine 2% op. soln (15ml bottle)†	1	3
Polymyxin Sulfate/TMP op. soln* (10ml bottle)†	1	3
Sulfacet Sodium 10% op. soln* (15ml bottle)†	1	3
Timolol Maleate 0.25% op. soln (5ml bottle)†	1	3
Timolol Maleate 0.5% op soln (5ml bottle)†	1	3
Tobramycin 0.3% op. soln (5ml bottle)†	1	3

Heart Health & Blood Pressure

Amiloride-HCTZ 5mg-50mg tab	30	90
Atenolol-Chlorthalidone 100mg	30	90
Atenolol 25mg tab	30	90
Atenolol 50mg tab	30	90
Atenolol 100mg tab	30	90
Benazepril 5mg tab	30	90
Benazepril 10mg tab	30	90
Benazepril 20mg tab	30	90
Benazepril 40mg tab	30	90
Bisoprolol-HCTZ 2.5mg-6.25mg tab	30	90

Prescription Program includes up to a 30-day supply for $4 and a 90-day supply for $10 of some covered generic drugs at commonly prescribed dosages. Higher dosages cost more. Prices for some drugs covered by the Prescription Program may be higher and may vary in some states. Restrictions apply. See Program Details or your Walmart Pharmacist for details. Free language assistance services available for prescription drug information at Walmart and Sam's Club pharmacies in New York. Contact your Walmart or Sam's Club pharmacy for details.

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	$4, 30-day	$10, 90-day
Bisoprolol-HCTZ 5mg-6.25mg tab	30	90
Bisoprolol-HCTZ 10mg-6.25mg tab	30	90
Bumetanide 0.5mg tab	30	90
Bumetanide 1mg tab	30	90
Captopril 12.5mg tab	60	180
Captopril 25mg tab	60	180
Captopril 50mg tab	60	180
Captopril 100mg tab	60	180
Carvedilol 3.125mg tab	60	180
Carvedilol 6.25mg tab	60	180
Carvedilol 12.5mg tab	60	180
Carvedilol 25mg tab*	60	180
Clonidine 0.1mg tab	30	90
Clonidine 0.2mg tab	30	90
Digoxin 0.125mg tab	30	90
Digoxin 0.25mg tab	30	90
Diltiazem 30mg tab	60	180
Diltiazem 60mg tab	60	180
Diltiazem 90mg tab*	60	180
Diltiazem 120mg tab	30	90
Doxazosin 1mg tab	30	90
Doxazosin 2mg tab	30	90
Doxazosin 4mg tab	30	90
Doxazosin 8mg tab	30	90
Enalapril-HCTZ 5mg-12.5mg tab	30	90
Enalapril 2.5mg tab	30	90
Enalapril 5mg tab	30	90
Enalapril 10mg tab	30	90
Enalapril 20mg tab	30	90
Furosemide 20mg tab	30	90
Furosemide 40mg tab	30	90
Furosemide 80mg tab	30	90
Guanfacine 1mg tab	30	90
Hydralazine 10mg tab	30	90
Hydralazine 25mg tab	30	90
Hydrochlorothiazide(HCTZ)12.5mg cap*	30	90
Hydrochlorothiazide (HCTZ) 25mg tab	30	90
Hydrochlorothiazide (HCTZ) 50mg tab	30	90
Indapamide 1.25mg tab	30	90
Indapamide 2.5mg tab	30	90

	$4, 30-day	$10, 90-day
Isosorbide Mononitrate 30mg ER tab	30	90
Isosorbide Mononitrate 60mg ER tab	30	90
Lisinopril-HCTZ 10mg-12.5mg tab	30	90
Lisinopril-HCTZ 20mg-12.5mg tab*	30	90
Lisinopril-HCTZ 20mg-25mg tab*	30	90
Lisinopril 2.5mg tab	30	90
Lisinopril 5mg tab	30	90
Lisinopril 10mg tab	30	90
Lisinopril 20mg tab	30	90
Methyldopa 250mg tab*	60	180
Methyldopa 500mg tab*	30	90
Metoprolol Tartrate 25mg tab	60	180
Metoprolol Tartrate 50mg tab	60	180
Metoprolol Tartrate 100mg tab*	60	180
Nadolol 20mg tab	30	90
Nadolol 40mg tab	30	90
Prazosin HCL 1mg cap	30	90
Prazosin HCL 2mg cap	30	90
Prazosin HCL 5mg cap	30	90
Propranolol 10mg tab	60	180
Propranolol 20mg tab	60	180
Propranolol 40mg tab	60	180
Propranolol 80mg tab	60	180
Sotalol HCL 80mg tab*	30	90
Spironolactone 25mg tab*	30	90
Terazosin 1mg cap	30	90
Terazosin 2mg cap	30	90
Terazosin 5mg cap	30	90
Terazosin 10mg cap	30	90
Triamterene-HCTZ 75mg-50mg tab	30	90
Triamterene-HCTZ 37.5mg-25mg tab	30	90
Verapamil 80mg tab	30	90
Verapamil 120mg tab	30	90
Warfarin 1mg tab	30	90
Warfarin 2mg tab	30	90
Warfarin 2.5mg tab	30	90
Warfarin 3mg tab	30	90
Warfarin 4mg tab	30	90
Warfarin 5mg tab*	30	90
Warfarin 6mg tab	30	90

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	$4, 30-day	$10, 90-day
Warfarin 7.5mg tab	30	90
Warfarin 10mg tab	30	90

Men's Health

	$9/30-day
Finasteride 5mg	30

Mental Health

Amitriptyline 10mg tab	30	90
Amitriptyline 25mg tab	30	90
Amitriptyline 50mg tab	30	90
Amitriptyline 75mg tab	30	90
Amitriptyline 100mg tab	30	90
Benztropine 2mg tab	30	90
Buspirone 5mg tab	60	180
Buspirone 10mg tab*	60	180
Carbamazepine 200mg tab*	60	180
Citalopram 20mg tab	30	90
Citalopram 40mg tab	30	90
Fluoxetine 10mg tab*	30	90
Fluoxetine 10mg cap	30	90
Fluoxetine 20mg cap	30	90
Fluoxetine 40mg cap	30	90
Fluphenazine 1mg tab	30	90
Haloperidol 0.5mg tab	30	90
Haloperidol 1mg tab	30	90
Haloperidol 2mg tab	30	90
Haloperidol 5mg tab	30	90
Lithium Carbonate 300mg cap*	90	270
Nortriptyline 10mg cap	30	90
Nortriptyline 25mg cap	30	90
Paroxetine 10mg tab*	30	90
Paroxetine 20mg tab*	30	90
Prochlorperazine 10mg tab	30	90
Thioridazine 25mg tab	30	90
Thioridazine 50mg tab	30	90
Thiothixene 2mg cap	30	90
Trazodone 50mg tab	30	90
Trazodone 100mg tab	30	90
Trazodone 150mg tab	30	90
Trihexyphenidyl 2mg tab	60	180

	$4, 30-day	$10, 90-day

Skin Conditions

Fluocinonide 0.05% cream* (15gm tube)†	1	3
Fluocinonide 0.05% cream* (30gm tube)†	1	3
Gentamicin 0.1% cream (15gm tube)†	1	3
Gentamicin 0.1% ointment (15gm tube)†	1	3
Hydrocortisone 1% cream (28.35-30g tube)†	1	3
Hydrocortisone 2.5% cream (30gm tube)†	1	3
Silver Sulfadiazine 1% cream* (50gm tube)†	1	3
Triamcinolone 0.025% cream (15gm tube)†	1	3
Triamcinolone 0.025% cream (80gm tube)†	1	3
Triamcinolone 0.1% cream (15gm tube)†	1	3
Triamcinolone 0.1% cream (80gm tube)†	1	3
Triamcinolone 0.1% ointment (15gm tube)†	1	3
Triamcinolone 0.1% ointment (80gm tube)†	1	3
Triamcinolone 0.5% cream (15gm tube)†	1	3

Thyroid Conditions

Levothyroxine 25mcg tab	30	90
Levothyroxine 50mcg tab	30	90
Levothyroxine 75mcg tab	30	90
Levothyroxine 88mcg tab	30	90
Levothyroxine 100mcg tab	30	90
Levothyroxine 112mcg tab	30	90
Levothyroxine 125mcg tab	30	90
Levothyroxine 137mcg tab	30	90
Levothyroxine 150mcg tab	30	90
Levothyroxine 175mcg tab*	30	90
Levothyroxine 200mcg tab*	30	90

Viruses

Acyclovir 200mg cap	30	90

Vitamins & Nutritional Health

Folic Acid 1mg tab	30	90
Mag 64 64mg tab*	60	180
Magnesium Oxide 400mg tab	30	90
Prenatal Plus qty 30*	30	90
Sodium Fluoride .25mg chewable (120ct bottle) †*	1	N/A

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	$4, 30-day	$10, 90-day
Women's Health		
Estradiol 0.5mg tab	30	90
Estradiol 1mg tab	30	90
Estradiol 2mg tab	30	90
MedroxyprogesteroneAcetate 2.5mg tab	30	90
Medroxyprogesterone Acetate 5mg tab	30	90
Medroxyprogesterone Acetate 10mg tab	10	30

	$9, 30-day	$24, 90-day
Alendronate SOD 35mg tab	4	12
Alendronate SOD 70mg tab	4	12
Clomiphene 50mg tab	5	15
Sprintec 28-day tab	28	N/A
Tamoxifen 10mg tab	60	180
Tamoxifen 20mg tab	30	90
Tri-Sprintec 28-day tab	28	N/A

Other Medical Conditions		
Chlorhexidine Gluconate 0.12% soln (473ml bottle)†	1	3
Hydrocortisone AC 25mg suppositories*	12	36
Isoniazid 300mg tab	30	90
Lidocaine 2% viscous solution (100ml bottle)†	1	3
Megestrol 20mg tab*	30	90
Oxybutynin 5mg tab*	60	180
Phenazopyridine 100mg tab	6	18
Phenazopyridine 200mg tab	30	90
Prednisone 2.5mg tab	30	90
Prednisone 5mg tab	30	90
Prednisone 10mg tab	30	90
Prednisone 20mg tab	30	90

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Alternative Pharmacy Options Outside Your Healthcare Plan

Walmart's Prescription Program Details

1. Walmart's Prescription Program (the "Program") is available at all Walmart, Sam's Club and Neighborhood Market pharmacies in the United States ("Walmart Retail Pharmacies"), except in North Dakota, as set forth below in Sections 3 and 4. The Program is also available through Walmart Mail Service ("Walmart Mail Service"), as set forth below in Section 5.
2. The Program applies only to certain generic drugs at commonly prescribed dosages. Higher dosages cost more. You may obtain a list of generic drugs and dosages covered under the Program at Walmart Retail Pharmacies (the "Retail Drug List") and through Walmart Mail Service (the "Mail Service Drug List") on Walmart.com or at Walmart Retail Pharmacies. The Retail Drug List and Mail Service Drug List may change and also may vary by state. Not all formulations of a drug (for example, enteric-coated, extended or timed release formulations) are covered under the Program. Program pricing not available when a covered drug is dispensed as part of a compound.
3. Under the Program at Walmart Retail Pharmacies, $4 is the price for up to a 30-day supply of certain covered generic drugs at commonly prescribed dosages (the "$4 Retail Program"). $10 is the price of a 90-day supply of certain covered generic drugs at commonly prescribed dosages (the "$10 Retail Program"). Not all drugs covered by the $4 Retail Program are covered by the $10 Program. Prices for quantities between a 30-day supply and a 90-day supply of drugs covered by both the $4 Retail Program and $10 Retail Program are prorated based on the $4 Program price, but will not exceed $10. Prices for quantities greater than a 90-day supply of drugs covered by the $10 Retail Program are prorated based on the $10 Program price. Prorated pricing is not available under the Program for prepackaged drugs. For pricing policies relating to prepackaged drugs (such as tubes, vials or bottles), see Section 6.
4. Under the Program at Walmart Retail Pharmacies, $9 is the price for up to a 30-day supply of certain women's health and other covered generic drugs at commonly prescribed dosages (the "$9 Retail Program"). $24 is the price for a 90-day supply of certain women's health and other covered generic drugs at commonly prescribed dosages (the "$24 Retail Program"). Not all drugs covered by the $9 Retail Program are covered by the $24 Retail Program. Prices for quantities between a 30-day supply and a 90-day supply of drugs covered by both the $9 Program and $24 Retail Program are prorated based on the $9 Program price, but will not exceed $24. Prices for quantities greater than a 90-day supply of drugs covered by the $24 Retail Program are prorated based on the $24 Program price. Prorated pricing is not available under the Program for prepackaged drugs. For pricing policies relating to prepackaged drugs, see Section 6.
5. Under the Program through Walmart Mail Service, $10 is the price for mail delivery of a 90-day supply of certain generic drugs at commonly prescribed dosages ("$10 Mail Service Program"). $24 is the price for mail delivery of certain women's health and certain other covered drugs at commonly prescribed dosages ($24 Mail Service Program"). Not all drugs covered by the $10 Retail Program are covered by the $10 Mail Service Program; not all drugs covered by the $24 Retail Program are covered by the $24 Mail Service Program. See Mail Service Drug List for a list of drugs covered by the $10 Mail Service Program and $24 Mail Service Program. Walmart Mail Service covers both initial fills and refills. Delivery of covered drugs is available only through Walmart Mail Service and is not available at Walmart, Sam's Club, and Neighborhood Market retail pharmacies. Delivery under the Program through Walmart Mail Service is limited to U.S. addresses by First-Class Mail; expedited delivery is also available for an additional charge. Some health plans do not cover Walmart Mail Service or 90-day supplies. Prices for quantities greater than a 90-day supply of drugs covered by the $10 Mail Service Program and the $24 Mail Service Program are prorated based on the $10 and $24 Program price, respectively. Prices for quantities less than a 90-day supply are not prorated under either the $10 Mail Service Program or the $24 Mail Service Program. Prorated pricing is not available under the Program for prepackaged drugs. For pricing policies relating to prepackaged drugs, see Section 6.
6. Prepackaged drugs are covered under the Program only in the unit sizes specified on the Retail Drug List and Mail Service Drug List. Prepackaged drugs are dispensed based on the quantities prescribed and unit sizes in stock at the dispensing pharmacy. Unit sizes not specified on the Retail Drug List or Mail Service Drug List are not covered under the Program. Multi-unit purchases are charged at a per unit price, based on the price per unit size dispensed, unless otherwise specified. Prepackaged drugs dispensed in unit sizes not specified on the Retail Drug List and Mail Service Drug List may be priced higher, even if equivalent quantities of the drug are available in specified unit sizes. Prorated pricing is not available under the Program for prepackaged drugs.
7. Prices of certain drugs covered by the Program may be higher in some states, as noted on the Retail Drug List and Mail Service Drug List.
8. Program pricing may be limited to select manufacturers of a covered drug and is available as long as supplies from such manufacturers are in stock at the dispensing pharmacy.
9. You may pay less or more than the Program price, depending on the terms of your health plan. Prescriber permission may be required to change a 30-day prescription to a 90-day prescription. Certain plans, including government-funded programs, may not cover a 90-day supply.
10. For purchases made at Walmart Retail Pharmacies, prescriptions must initially be filled in person, and refills must be picked up in store. There are no substitutions. Purchases made through Walmart Mail Service may be ordered at Walmart Retail Pharmacies, by phone or through walmart.com.
11. These Program Details are subject to change without advance notice. Changes to these Program Details may be made only in writing.

Prescription Program includes up to a 30-day supply for $4 and a 90-day supply for $10 of some covered generic drugs at commonly prescribed dosages. Higher dosages cost more. Prices for some drugs covered by the Prescription Program may be higher and may vary in some states. Restrictions apply. See Program Details or your Walmart Pharmacist for details. Free language assistance services available for prescription drug information at Walmart and Sam's Club pharmacies in New York. Contact your Walmart or Sam's Club pharmacy for details.

*Prices may be higher in CA, HI, MN, MT, PA, TN and WI.
†Prepackaged drugs are covered only in unit sizes specified on Drug List. See Program Details or your Walmart Pharmacist for details.

Revised 8/1/2012

Walmart Save money. Live better. | Sam's Club Savings Made Simple

$4 and $10 Generic Medication List (sorted by disease state)

PHARMACY

Generic Drug Name/ Strength	Form	$4 30-Day QTY	$10 90-Day QTY
Allergy, Cough and Cold			
Benzonatate 100 Mg	Capsule	14	42
Loratadine 10 Mg	Tablet	30	90
Promethazine 6.25 Mg/5 Ml*	Syrup	180	540
Promethazine Dm	Syrup	120	360
Analgesic			
Baclofen 10 Mg	Tablet	30	90
Cyclobenzaprine 5 Mg	Tablet	30	90
Cyclobenzaprine 10 Mg	Tablet	30	90
Diclofenac Er 75 Mg	Tablet	60	180
Ibuprofen 100 Mg/5 Ml*	Suspension	120	360
Ibuprofen 400 Mg	Tablet	90	270
Ibuprofen 600 Mg	Tablet	60	180
Ibuprofen 800 Mg	Tablet	30	90
Indomethacin 25 Mg*	Capsule	60	180
Meloxicam 7.5/15 Mg	Tablet	30	90
Naproxen 375/500 Mg*	Tablet	60	180
Anti-Anxiety			
Buspirone 5/10 Mg*	Tablet	60	180
Paroxetine 10/20 Mg*	Tablet	30	90
Antibiotic			
Amoxicillin 125 Mg/5 Ml	Suspension	80	240
Amoxicillin 125 Mg/5 Ml	Suspension	100	300
Amoxicillin 125 Mg/5 Ml	Suspension	150	450
Amoxicillin 200 Mg/5 Ml	Suspension	50	150
Amoxicillin 200 Mg/5 Ml*	Suspension	75	225
Amoxicillin 200 Mg/5 Ml*	Suspension	100	300
Amoxicillin 250 Mg	Capsule	30	90
Amoxicillin 250 Mg/5 Ml	Suspension	80	240
Amoxicillin 250 Mg/5 Ml	Suspension	100	300
Amoxicillin 250 Mg/5 Ml	Suspension	150	450
Amoxicillin 400 Mg/5 Ml	Suspension	50	150
Amoxicillin 400 Mg/5 Ml*	Suspension	75	225
Amoxicillin 400 Mg/5 Ml*	Suspension	100	300
Amoxicillin 500 Mg	Capsule	30	90
Cephalexin 250 Mg	Capsule	28	84
Cephalexin 500 Mg	Capsule	30	90
Ciprofloxacin 250 Mg	Tablet	14	42
Ciprofloxacin 500 Mg	Tablet	20	60
Doxycycline Hyclate 50 Mg	Capsule	30	90
Doxycycline Hyclate 100 Mg	Capsule/ Tablet	20	60
Isoniazid 300 Mg	Tablet	30	90
Penicillin Vk 125 Mg/5Ml	Solution	100	300
Penicillin Vk 125 Mg/5 Ml	Solution	200	600
Penicillin Vk 250 Mg/5 Ml	Solution	100	300
Penicillin Vk 250 Mg	Tablet	28	84
Smz/Tmp 200/40/5 Ml*	Suspension	120	360
Smz/Tmp 400/80 Mg	Tablet	28	84
Smz/Tmp Ds 800/160 Mg	Tablet	20	60
Antidepressant			
Amitriptyline 10/25/50/75/100 Mg	Tablet	30	90
Citalopram 20/40 Mg	Tablet	30	90
Fluoxetine 10 Mg*	Tablet	30	90
Fluoxetine 10/20/40* Mg	Capsule	30	90
Nortriptyline 10/25 Mg	Capsule	30	90
Paroxetine 10/20 Mg*	Tablet	30	90
Trazodone 50/100/150 Mg	Tablet	30	90
Antifungal			
Fluconazole 150 Mg	Tablet	1	3
Terbinafine 250 Mg*	Tablet	30	90
Anti-Inflammatory			
Diclofenac Er 75 Mg	Tablet	60	180
Ibuprofen 100 Mg/5 Ml*	Suspension	120	360
Ibuprofen 400 Mg	Tablet	90	270
Ibuprofen 600 Mg	Tablet	60	180
Ibuprofen 800 Mg	Tablet	30	90
Indomethacin 25 Mg*	Capsule	60	180
Meloxicam 7.5/15 Mg	Tablet	30	90
Naproxen 375/500 Mg*	Tablet	60	180
Antipsychotic			
Fluphenazine 1 Mg	Tablet	30	90
Haloperidol 0.5/1/2/5 Mg	Tablet	30	90
Lithium Carb 300 Mg*	Capsule	90	270
Thioridazine 25/50 Mg	Tablet	30	90
Thiothixene 2 Mg	Capsule	30	90
Antiviral			
Acyclovir 200 Mg	Capsule	30	90
Arthritis			
Diclofenac Er 75 Mg	Tablet	60	180
Ibuprofen 400 Mg	Tablet	90	270
Ibuprofen 600 Mg	Tablet	60	180
Ibuprofen 800 Mg	Tablet	30	90
Indomethacin 25 Mg*	Capsule	60	180
Meloxicam 7.5/15 Mg	Tablet	30	90
Naproxen 375/500 Mg*	Tablet	60	180
Asthma			
Albuterol 2 Mg/5 Ml	Syrup	120	360
Albuterol 2 Mg	Tablet	90	270
Albuterol 4 Mg	Tablet	60	180
Albuterol Neb 0.083%*	Solution	75	225
Albuterol Neb 0.5%*	Solution	20	60
Ipratropium Neb 0.2 Mg/Ml*	Solution	75	225
Cancer/Oncology			
Megestrol 20 Mg*	Tablet	30	90
Cardiac/Hypertension			
Amiloride/Hctz 5-50 Mg	Tablet	30	90
Atenolol 25/50/100 Mg	Tablet	30	90
Atenolol/Chlorthal 100/25 Mg	Tablet	30	90
Benazepril 5/10/20/40 Mg	Tablet	30	90
Bisoprolol/Hctz 2.5/6.25 Mg	Tablet	30	90
Bisoprolol/Hctz 5/6.25 Mg	Tablet	30	90
Bisoprolol/Hctz 10/6.25 Mg	Tablet	30	90
Bumetanide 0.5/1 Mg	Tablet	30	90

Generic Drug Name/ Strength	Form	$4 30-Day QTY	$10 90-Day QTY
Captopril 12.5/25/50/100 Mg	Tablet	60	180
Carvedilol 3.125/6.25/12.5 Mg	Tablet	60	180
Carvedilol 25 Mg*	Tablet	60	180
Clonidine 0.1/0.2 Mg	Tablet	30	90
Digoxin 0.125/0.25 Mg	Tablet	30	90
Diltiazem 30/60/90* Mg	Tablet	60	180
Diltiazem 120 Mg	Tablet	30	90
Doxazosin 1/2/4/8 Mg	Tablet	30	90
Enalapril 2.5/5/10/20 Mg	Tablet	30	90
Enalapril/Hctz 5/12.5 Mg	Tablet	30	90
Furosemide 20/40/80 Mg	Tablet	30	90
Guanfacine 1 Mg	Tablet	30	90
Hydralazine 10/25 Mg	Tablet	30	90
Hydrochlorothiazide 12.5*/25/50 Mg	Capsule	30	90
Indapamide 1.25/2.5 Mg	Tablet	30	90
Isosorbide Mononitrate Er 30/60 Mg	Tablet	30	90
Lisinopril 2.5/5/10/20 Mg	Tablet	30	90
Lisinopril/Hctz 10-12.5 Mg	Tablet	30	90
Lisinopril/Hctz 20-12.5 Mg*	Tablet	30	90
Lisinopril/Hctz 20-25 Mg*	Tablet	30	90
Methyldopa 250 Mg*	Tablet	60	180
Methyldopa 500 Mg*	Tablet	30	90
Metoprolol Tartrate 25/50/100* Mg	Tablet	60	180
Nadolol 20/40* Mg	Tablet	30	90
Prazosin Hcl 1/2*/5* Mg	Capsule	30	90
Propranolol 10/20/40/80 Mg	Tablet	60	180
Sotalol Hcl 80 Mg*	Tablet	30	90
Spironolactone 25 Mg*	Tablet	30	90
Terazosin 1/2/5/10 Mg	Capsule	30	90
Triamterene/Hctz 37.5/25 Mg	Tablet	30	90
Triamterene/Hctz 75/50 Mg	Tablet	30	90
Verapamil 80/120 Mg	Tablet	30	90
Warfarin 1/2/2.5/3/4/5*/6/7.5/10 Mg	Tablet	30	90
Cholesterol			
Lovastatin 10/20 Mg*	Tablet	30	90
Pravastatin 10/20/40* Mg	Tablet	30	90
Diabetes			
Glimepiride 1/2/4 Mg	Tablet	30	90
Glipizide 5 Mg	Tablet	30	90
Glipizide 10 Mg*	Tablet	60	180
Glyburide 2.5/5 Mg	Tablet	30	90
Glyburide Micro 3/6 Mg	Tablet	30	90
Metformin 500/850/1000* Mg	Tablet	60	180
Metformin Er 500 Mg*	Tablet	60	180
Ear Preparations			
Antipyrine/Benzocaine	Otic Solution	10	30
Eye Preparations			
Atropine Sulfate 1%	Ophthalmic Solution	5	15
Erythromycin 5 Mg/Gm*	Ophthalmic Ointment	4	12
Gentamicin 0.3%	Ophthalmic Solution	5	15
Levobunolol 0.5%	Ophthalmic Solution	5	15
Neo/Polymx/Dexamethasone 0.1%	Ophthalmic Ointment	4	12
Neo/Polymx/Dexamethasone 0.1%	Ophthalmic Suspension	5	15
Pilocarpine 1%/2%	Ophthalmic Solution	15	45
Polymyxin Sulfate/Tmp*	Ophthalmic Solution	10	30
Sulfacetamide Sodium 10%	Ophthalmic Solution	15	45
Timolol Maleate 0.25%/0.5%	Ophthalmic SolutioN	5	15
Tobramycin 0.3%	Ophthalmic Solution	5	15
Hormones			
Estradiol 0.5/1/2 Mg	Tablet	30	90
Medroxyprogesterone 2.5/5 Mg	Tablet	30	90
Medroxyprogesterone 10 Mg	Tablet	10	30
Incontinence			
Oxybutynin 5 Mg*	Tablet	60	180
Muscle Relaxants			
Baclofen 10 Mg	Tablet	30	90
Cyclobenzaprine 5/10 Mg	Tablet	30	90
Other			
Allopurinol 100/300 Mg	Tablet	30	90
Carbamazepine 200 Mg*	Tablet	60	180
Chlorhexidine Gluconate 0.12%	Solution	473	1419
Cytra-2	Solution	180	540
Phenazopyridine 100 Mg	Tablet	6	18
Phenazopyridine 200 Mg	Tablet	30	90
Prochlorperazine 10 Mg	Tablet	30	90
Parkinson's Disease			
Benztropine 2 Mg	Tablet	30	90
Trihexyphenidyl 2 Mg	Tablet	60	180
Prostate/Bph			
Doxazosin 1/2/4/8 Mg	Tablet	30	90
Megestrol 20 Mg*	Tablet	30	90
Prazosin Hcl 1/2*/5* Mg	Capsule	30	90
Terazosin 1/2/5/10 Mg	Capsule	30	90
Seizure/Epilepsy			
Carbamazepine 200 Mg*	Tablet	60	180
Steroids			
Dexamethasone 0.75 Mg	Tablet	12	36
Dexamethasone 0.5 Mg	Tablet	30	90
Dexamethasone 4 Mg	Tablet	6	18
Prednisone 2.5/5/10/20 Mg	Tablet	30	90
Stomach Disorders/Gastrointestinal			
Belladonna Alkaloids/Pb	Tablet	60	180
Cimetidine 800 Mg*	Tablet	30	90
Dicyclomine 10 Mg	Capsule	90	270
Dicyclomine 20 Mg	Tablet	60	180
Famotidine 20 Mg	Tablet	60	90
Hydrocortisone Ac 25 Mg	Suppository	12	36
Lactulose 10 Gm/15 Ml	Syrup	237	711
Metoclopramide 5 Mg/5 Ml	Syrup	60	180
Metoclopramide 10 Mg	Tablet	60	180
Prochlorperazine 10 Mg	Tablet	30	90
Promethazine 25 Mg*	Tablet	12	36
Ranitidine 150 Mg	Tablet	60	180

Generic Drug Name/ Strength	Form	$4 30-Day QTY	$10 90-Day QTY
Ranitidine 300 Mg	Tablet	30	90
Thyroid			
Levothyroxine 25/50/75/ 88/100/112/125/137/150/175 */200* Mcg	Tablet	30	90
Topical Preparations			
Fluocinonide 0.05%*	Cream	15	45
Fluocinonide 0.05%*	Cream	30	90
Gentamicin 0.1%	Cream/ Ointment	15	45
Hydrocortisone 1%	Cream	30	90
Hydrocortisone 2.5%	Cream	30	90
Lidocaine Viscous 2%	Solution	100	300
Nystatin 100,000u*	Cream	15	45
Nystatin 100,000u*	Cream	30	90
Silver Sulfadiazine 1%*	Cream	50	150
Triamcinolone 0.025%	Cream	15	45
Triamcinolone 0.025%	Cream	80	240
Triamcinolone 0.1%	Cream/ Ointment	15	45
Triamcinolone 0.1%	Cream/ Ointment	80	240
Triamcinolone 0.5%	Cream	15	45
Tuberculosis			
Isoniazid 300 Mg	Tablet	30	90
Vitamins/Supplements			
Folic Acid 1 Mg	Tablet	30	90
Magnesium Oxide 400 Mg	Tablet	30	90
Mag64 64 Mg*	Tablet	60	180
Prenatal Plus*	Tablet	30	N/A
Sodium Fluoride 0.5 Mg*	Tablet	120	N/A

Generic Drug Name/ Strength	Form	$9 30-Day Qty	$24 90-Day Qty
Women's Health			
Alendronate Sod 35/70 Mg	Tablet	4	12
Clomiphene 50 Mg	Tablet	5	15
Sprintec 28-Day*	Tablet	28	N/A
Tamoxifen 10 Mg	Tablet	60	180
Tamoxifen 20 Mg	Tablet	30	90
Tri-Sprintec 28-Day*	Tablet	28	N/A
Men's Health			
Finasteride 5mg	Tablet	30	N/A

$4 prescriptions include up to a 30-day supply of covered drugs at commonly prescribed dosages. $10 prescriptions include up to a 90-day supply of covered drugs at commonly prescribed dosages. Physician permission may be required to change a 30-day prescription to a 90-day prescription.

*These drugs may be priced higher in CA, HI, MN, MT, PA, RI, TN, WI, and WY. Please ask your Target Pharmacist for specific pricing in these states.

This list is also available at Target.com/Pharmacy

Alternative Pharmacy Options Outside Your Healthcare Plan

August 2012

Declination of Healthcare Coverage Affidavit

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 OAP 20 (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's 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

Florida KidCare Comparison Chart

Annual deductibles and maximums	KidCare
Lifetime maximum	$1 million lifetime max
Pre-Existing Condition Limitation (PCL)	N/A
Coinsurance	N/A
Maximum Reimbursable Charge	N/A
Calendar year plan deductible	N/A
Calendar year out-of-pocket maximum	N/A
Office Visit	PCP/Specialist $5 Co-pay Podiatry Visit $5 Co-pay
Physician Services (hospital) • In hospital visits and consultations • Inpatient • Outpatient	1 Visit/Per Day/2 Months covered 100%

Florida KidCare Comparison Chart

Benefits	KidCare
Surgery (in a physician's office)	PCP/Specialist $5 Co-pay
Preventive care	
Children (to age 16) • Includes well-baby and well-child • Includes immunizations • Includes lab and x-ray billed by the doctor's office	$0 Co-pay 100% Covered
Immunizations	Covered after office visit Co-pay
PSA, Pap Smear and Maternity Screening • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	100% Covered
Inpatient hospital facility services	
Semi-private room and board and other non-physician services • Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. • Private room stays may result in extra charges for the patient.	$0 Co-pay 100% Covered
Inpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	$0 Co-pay 100% Covered

Florida KidCare Comparison Chart

Benefits	KidCare
Outpatient services	
Outpatient surgery (facility charges)	$5 Co-pay
Outpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	$5 Co-pay
Physical, occupational and speech therapy	$5 Co-pay PT, OT, RT, ST 24 Treatments within 60 days per initial episode
Chiropractic care	$5 Co-pay 24 visits per year
Laboratory (includes pre-admission testing)	
Lab • Physician's office	100% Covered after office visit Co-pay $5

Florida KidCare Comparison Chart

Benefits	KidCare
Lab	$0 Co-pay
Lab, emergency room and urgent care	$0 Co-pay
Radiology Services (includes pre-admission testing) **X-ray** • Physician's office visit	$0 Co-pay 100% Covered - Test
X-ray • Outpatient hospital facility • Independent x-ray facility, hospital based or affiliated • Independent x-ray facility, non-hospital based or affiliated	$0 Co-pay 100% Covered
X-ray, emergency room and urgent care	$0 Co-pay
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	$0 Co-pay 100% Covered
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	$0 Co-pay 100% Covered

Florida KidCare Comparison Chart

Benefits	KidCare
Emergency and urgent care services	
Hospital emergency room	Inappropriate use of ER - $10 Co-pay (non emergencies)
Ambulance	$10 Co-pay
Other health care facilities	
Skilled nursing facility, rehabilitation hospital and other facilities	$0 Co-pay 100 Days per year
Home health care	$5 Co-pay Unlimited
Hospice	$5 Co-pay Unlimited
Other health care services	
Durable medical equipment • Unlimited calendar year maximum	$0 Co-pay 100% Covered Plan Approval Required

Florida KidCare Comparison Chart

Benefits	
External prosthetic appliances (EPA)	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
TMJ, surgical and non-surgical	Not Covered
Maternity care services	
• Covers maternity for employee and all dependents. (Including Midwife Services)	3 days maximum limited to vaginal delivery
• Initial visit to confirm pregnancy	No Co-pay
• Pre & Post Natal Office Visits	No Co-pay - infant is covered for up to three days following birth or until the infant is transferred to another medical facility, whichever comes first. And coverage may be limited to the fee for vaginal deliveries.

Florida KidCare Comparison Chart

Benefits	KidCare
Family planning • Inpatient hospital facility	Family planning limited to one annual visit and one supply visit each ninety days.
Inpatient mental health services	$0 Co-pay 100% Covered
Outpatient mental health physician's office services	$0 Co-pay 100% Covered
Outpatient mental health facility services	$5 Co-pay
Inpatient substance abuse services	$0 Co-pay

Florida KidCare Comparison Chart

Benefits	
Outpatient substance abuse physician's office services	$5 Co-pay
Outpatient substance abuse facility services	$5 Co-pay
Prescription Drugs	$5 Co-pay up to 31 day supply 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.
Vision Care	$0 Co-pay - Vision Hearing - No Co-pay for hearing screening by primary care physician.

Getting FSA Answers

In compliance with the Patient Protection and Affordable Care Act (PPACA Healthcare Reform), the Medical Flexible Spending Account annual maximum contribution limit has been reduced to $2,500.

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

Website

The Website provides information regarding your benefits and comprehensive details on your FSAs.

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

Benefits

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

Claims

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

Accounts

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

myFBMC Card® Visa® Card

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

Profile

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

Resources

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

Forms

Download applicable forms for claim submission and reimbursement.

Interactive Benefits

Our 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1.800.865.FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

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

Personal Identification Number (PIN)

To access the IVR system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN. After your initial login, you will be asked to register and select your own confidential PIN to access this system in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero..

Record PIN here.
Remember, this will be your PIN for IVR access.

If you forget your PIN, call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262).

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

Go Green for Instant Information

With Go Green, you can review and print your real-time account information at any time and receive real-time updates about the following events:

- Claims are received
- Claims are paid
- Claims are partially or fully rejected
- myFBMC Card® documentation needed
- myFBMC Card® suspension warning
- myFBMC Card® suspended
- myFBMC Card® reinstated
- New Online Statement notification

Going Green makes it easy to track claims and manage your account, while reducing your carbon footprint. To enroll, simply register or log in to **www.myFBMC.com**, click on the "Go Green" box under "Account Access" and you're on your way to simpler account management.

Stop wondering about your claims - know when they're received, paid or need more documentation instantly! Stop waiting for paper statements to arrive in the mail, they are available online anytime! Go Green at **www.myFBMC.com**, to stop wondering, stop waiting and start benefiting today.

Flexible Spending Accounts (FSAs)

Reimbursement Methods for Medical FSAs:

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

Direct Deposit

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

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

To apply, visit **www.myFBMC.com** or call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262). Please note that processing your Direct Deposit enrollment may take between four to six weeks.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact the Service Center.

- Visit **www.myFBMC.com**
- Call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262) (Monday-Friday, 7 a.m. - 8 p.m. ET).

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

What is a Flexible Spending Account?

WageWorks provides you with IRS tax-favored Flexible Spending Accounts (FSAs) to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

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

Is an FSA right for me?

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

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

What types of FSAs are available?

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

Medical Expense FSAs

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

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-counter items (Prescription required).

Dependent Care FSAs

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

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

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

Receiving Reimbursement

ONLINE CLAIMS SUBMISSION:

Submit your claims online at **www.myFBMC.com**. Here you can easily submit a scanned image of your completed claim form along with scans of supporting documentation.

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

If you have questions regarding online claims submission, contact the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262) (Monday - Friday 7 a.m. - 8 p.m. ET).

OR RECEIVE REIMBURSEMENT BY MAIL:

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

Flexible Spending Accounts (FSAs)

How do I request reimbursement?

For Medical Expense FSA:

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

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

For Dependent Care FSA:

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

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

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

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

Fax Toll-Free to: 1.888.800.5217
Mail to: WageWorks
P.O. Box 1800
Tallahassee, FL 32302-1800

Reimbursement Methods for Medical FSAs:

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

Direct Deposit

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

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

To apply, visit **www.myFBMC.com** or call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262). Please note that processing your Direct Deposit enrollment may take between four to six weeks.

Where can I get information about FSAs?

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

- Visit **www.myFBMC.com**
- Call the **FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262) (Monday-Friday, 7 a.m. - 8 p.m. ET).**

Please note your account information with others without your verbal or written authorization.

FSA Savings Example*

(With FSA)		*(Without FSA)*
$31,000	Annual Gross Income	$31,000
- 2,500	FSA Deposit for Recurring Expenses	- 0
$28,500	Taxable Gross Income	$31,000
- 6,455.25	Federal, Social Security Taxes	- 7,021.50
$22,044.75	Annual Net Income	$23,978.50
- 0.00	Cost of Recurring Expenses	-2,500.00
$22,044.75	Spendable Income	$21,478.50

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

$566.25!

Notes: The "payroll tax holiday" expired on December 31, 2012, resulting in an increase in the employee portion of Social Security taxes from 4.2% to 6.2% as of January 1, 2013. The reduction in Social Security tax has now expired and employees will see the additional 2% taken out of their paychecks, up to the Social Security wage base for 2013, $113,700. More information can be found in IRS Notice 1036.

Medical Expense FSA

Minimum Annual Deposit: $200
Maximum Annual Deposit: $2,500

NOTE: Employees hired mid-year must calculate minimum/maximum amounts based on remaining payroll deductions. Effective January 1, 2013 the maximum annual contribution amount for a Medical Expense Flexible Spending Account (FSA) will be $2,500. This change does not affect your 2012 contribution limit. If you are contributing less than $2,500 to your 2012 Medical FSA and expect to incur more expenses in 2013, during this enrollment time, you are provided the opportunity to increase the amount. Please plan accordingly.

What is a Medical Expense FSA?

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

Whose expenses are eligible?

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

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

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

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- has a specified family-type relationship to you
- lives in your household for more than half of the taxable year
- is 18 years old or younger (26 years, if a full-time student) at the end of the taxable year and
- has not provided more than one-half of their own support during the taxable year.

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

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

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

Visit www.myFBMC.com for a list of frequently asked questions.

You must keep your documentation for a minimum of one year and submit to FBMC upon request.

Can travel expenses for medical care be reimbursed?

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

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

When are my funds available?

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

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

Partial List of Medically Necessary Eligible Expenses*

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

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

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

Medical Expense FSA

Are prescriptions eligible for reimbursement?

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

Over-the-Counter Expenses

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

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

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

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

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

Eligible Over-the-Counter (OTC) drugs and medicines require a prescription from your physician to qualify for reimbursement. It's important to remember that you can still use your FSA funds for other eligible medical expenses and prescription purchases at pharmacies. Non-drug and non-medicine items that aren't subjected to new OTC laws may still be purchased normally. Please visit **www.myFBMC.com** for more information. If you have any questions, please contact the Service Center.

Is orthodontic treatment reimbursable?

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

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

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262).

Should I claim my expenses on IRS Form 1040?

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

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

Are some expenses ineligible?

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

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

When do I request reimbursement?

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

FSA Worksheets

Medical Expense FSA Worksheet

TAX-FREE MEDICAL EXPENSE	FSA PROJECTED EXPENSES
Medical deductible, co-insurance	$ _____
Medical & prescription co-payments	$ _____
Dental deductible, co-insurance or co-payments	$ _____
Immunizations, injections & vaccinations	$ _____
Routine exams and physicals	$ _____
Orthodontic expenses*	$ _____
Vision exams	$ _____
Eyeglasses & contacts (corrective)	$ _____
Hearing exams	$ _____
Other expenses	$ _____

2. **Total uninsured eligible expenses,** January 1, 2013, through December 31, 2013. Amount cannot exceed $2,500. $ _____

NOTE: January 1, 2013 applies only to new participants.

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

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

Minimum annual amount: $200.

Maximum: $2,500 contribution.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit. Visit www.myFBMC.com to download this form or call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262).

Note: Contribute conservatively. No reimbursements of funds is available for services that do not occur during the current plan year. Remaining funds will be forfeited.

Dependent Care FSA Worksheet

1. **Multiply** your weekly day care expenses by the number of weeks you expect to have the expenses January 1, 2013, through December 31, 2013. $ _____

NOTE: January 1, 2013, applies only to new participants.

2. **DIVIDE** by the number of payroll deductions in the plan year. This is the amount taken from each paycheck and deposited into your Dependent Care FSA. Amount cannot exceed your maximum tax filing status. See Page 95 for details. $ _____

Minimum annual amount: $250.

Maximum: $5,000 contribution.

(maximum amount based on your tax filing status)

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit. Visit www.myFBMC.com to download this form or call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262).

NOTE: Contribute conservatively. The commencement of the school year (August) does not qualify for a reduction or an event to stop your account. No reimbursement of funds is available for services that do not occur during the current plan year. Remaining funds will be forfeited.

Dependent Care FSA

Minimum Annual Deposit: $250
Maximum Annual Deposit: $5,000 (The maximum contribution depends on your tax filing status as the list on this page indicates†.)

What is a Dependent Care FSA?

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

Whose expenses are eligible?

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

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

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

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

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

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

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

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

Partial List of Eligible Dependent Care Expenses*

After school care
Baby-sitting fees
Day care services
In-home care/au pair services
Nursery and preschool
Summer day camps

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

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

† What is my maximum annual deposit?

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

When are my funds available?

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

Should I claim tax credits or exclusions?

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

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

Dependent Care FSA

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

Are some expenses ineligible?

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

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

Will I need to keep any additional documentation?

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

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

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

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

When do I request reimbursement?

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

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

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

How do I request reimbursement?

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

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

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

Fax Toll-Free to: 1.888.800.5217

Mail to: WageWorks
P.O. Box 1800
Tallahassee, FL 32302-1800

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

Flexible Spending Accounts (FSAs)

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Medical Expense FSA or vice versa.
3. You have a three month and 15 day run-out period (until April 15) at the end of the plan year for reimbursement of eligible Medical Expense FSA expenses incurred during your period of coverage and any applicable grace period within the Plan Year.
4. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service which you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the 2013 Plan Year. IRS regulations state that any unused funds which remain in your FSA after the run-out period ends and all reimbursable requests have been submitted and processed cannot be returned to you nor carried forward to the next plan year. Use the FSA Calculation Worksheet on Page 94 to determine your annual contribution estimate.
8. When enrolling in either or both FSAs, written notice of agreement with the following will be required.
   - I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents
   - I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
   - I will not seek reimbursement through any additional source and
   - I will collect and maintain sufficient documentation to validate the foregoing.
   - **I agree to a salary deduction for the amount of any outstanding myFBMC Card® transactions (as permitted by law) if I do not send in documentation for an unverified myFBMC Card® expense. See Page 98 for details on the card.**

What documentation of expenses do I need to keep?

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

How do I get the forms I need?

To obtain forms after enrolling in either a Medical Expense or Dependent Care FSA, such as an FSA Claim Form, Letter of Medical Need or Direct Deposit Form, visit FBMC's website, **www.myFBMC.com** or call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262)

Will contributions affect my income taxes?

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

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

FSA Grace Period

IRS Revenue Notice permits a "**grace period**" of two months and 15 days following the end of your 2013 Plan Year (December 31, 2013) for a Medical Expense FSA. This grace period ends on March 15, 2014. **During the grace period, you may incur expenses and submit claims for these expenses.** Funds will be automatically deducted from any remaining dollars in your 2013 Medical Expense FSA.

You should not confuse the grace period with the plan's "**run-out period**." The run-out period extends until April 15, 2014. This is a period for filing claims incurred anytime during the 2013 Plan Year, as well as claims incurred during the grace period mentioned above.

Effective January 1, 2013, the maximum annual contribution amount for a Medical Expense Flexible Spending Account (FSA) will be $2,500. This change does not affect your 2012 contribution limit. If you are contributing less than $2,500 to your 2012 Medical FSA and expect to incur additional expenses in 2013, please plan accordingly.

Your Dependent Care FSA also has a "run-out period" that extends until March 31, 2014. However, the "grace period" mentioned above does not apply to this account. You may not submit reimbursement requests for expenses that occur after December 31, 2013, against the 2013 Plan Year.

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

myFBMC Visa® Card®

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

What is the myFBMC Card®?

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

What are the myFBMC Card® advantages?

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

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

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

How do I get a myFBMC Card®?

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

How do I use the myFBMC Card®?

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

NOTE: Your myFBMC® Card can be swiped for set co-payments in your healthcare plan. Amount being swiped must match the exact out-of-pocket cost in accordance to the plan design as as stated in the healthcare section of this online Benefits Guide.

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

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

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

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

As an FSA participant, you should go to **www.myFBMC.com** to see your account information and check for any outstanding Card transactions. If an outstanding transaction is highlighted on your monthly statement, you must submit the proper expense documentation to FBMC prior to the end of your run out period.

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

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

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

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

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

These funds will be used first until exhausted — through March 15, 2013, which is the grace period allowed by the IRS. Then, subsequent claims will be debited from your new plan year account balance. For more information on the grace period, see Page 98.

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

myFBMC Visa® Card®

How To Guide

About Your Card

While your myFBMC Card® (the Card) and account offer a great deal of convenience, both are regulated by IRS rules that all participants are required to follow. In most instances, you will be able to use your Card with little or no inconvenience. There are, however, situations where the Card will be declined or you will be required to submit receipts and/or other documentation to verify that the item or service purchased was eligible.

How To...

Use your Card

You can use your myFBMC Card® in these ways:

1) For eligible goods and services at health care providers and select pharmacies
2) For eligible over-the-counter (OTC) non-drug items at general merchandise stores (including most drugstores) that have an industry standard (IIAS) inventory and checkout system
3) For prescribed OTC drugs and medicines at the pharmacy counter, as long as the drug is dispensed as a valid prescription

Go to **www.myFBMC.com** to learn more about the OTC drug prescription requirement.

In most instances, your Card transaction will be verified at checkout, which means you will not have to submit a receipt after the transaction. You are, however, required to keep each receipt for tax purposes, and in the event it is needed for verification.

Before shopping for prescriptions and over-the-counter items, always visit www.sigis.com for a list of merchants that have an IIAS system in place.

Use your Card at the doctor or other health care provider

If you use the Card at a health care provider or at a non-IIAS pharmacy that does not have an IIAS system, we will likely require that you submit a receipt or your health insurance explanation of benefits (EOB) to verify that the transaction was for an eligible health care good or service.

Verify a Card transaction after the purchase

If we are unable to determine that your Card was used to pay for eligible health care products and services, you will need to take the following action to verify the transaction:

- Log into your account at **www.myFBMC.com** and download a Claim Form from the Forms menu
- Fill out the Claim Form and fax toll-free to 1-866-923-6319
- Include proper documentation (see the next section to know exactly what is required).

If you have lost or misplaced the receipt, you can submit a substitute receipt of equivalent value or repay your account.

Make sure your receipts meet the requirements for verification

In order for the receipt (or any documentation) to be valid, it must include the five specific pieces of information required by the IRS:

- The patient name
- Provider name
- Date of service
- Type of service
- The amount you were charged or your cost (e.g. your deductible or copay amount or the portion not covered by your insurance)
- For OTC drug prescriptions, the receipt must also include the prescription number. If not included, a copy of the prescription must accompany the receipt instead.

Know when a Card transaction needs to be verified

When you sign up to Go Green at **www.myFBMC.com**, we will notify you of any Card transactions that require attention by email and when you log onto your account.

Quick Tips

Log onto your account at www.myFBMC.com regularly to see if you have any Card transactions in need of verification.

Any transactions that are highlighted in color online are outstanding and you'll need to submit documentation.

Avoid problems: act quickly to resolve all unverified transactions.

You have 90 days from the date of the transaction to take care of any outstanding unverified purchases. If you do not take action within 90 days:

1. The amount of any outstanding unverified Card transactions may be deducted from your next claim submission.
2. Your Card will be suspended.

If your Card is suspended, it will be reactivated within 24 – 48 hours after receipts or repayment have been processed for all unverified Card transactions.

www.myFBMC.com

FBWW-CARD-HOWTO-SLC (Oct 2011)

MetLife Dental Comparison Chart

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

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

† South Florida (Area 3) consists of zip codes that begin with the digits 330, 331, 333, 334, 339, 340, 349, 320-329, 335-338, 341-348. If you do not reside in a zip code that begins with these digits, please contact MetLife at 1.800.942.0854 for a more accurate in-network schedule of benefits and fees.

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

** Out-of-Network: Member pays balance of PDP fees, in addition to the remaining balance of claim. Balance equals the difference between total claim and PDP fee. For information on PDP fees in your area, contact MetLife directly at 1.800.942.0854.

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

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

See Page 92 for a partial list of eligible expenses or visit FBMC's website at www.myFBMC.com for the full version of eligible expenses.

SafeGuard Standard DHMO Plan

SafeGuard Standard DHMO Plan - SGC1033

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

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

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

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

Schedule of Benefits

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

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

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

Preventive Services		member pays
D1110	Prophylaxis - adult	$0
	• Additional - adult prophylaxis, with or without fluoride (maximum of 2 additional per year)	$35
D1120	Prophylaxis - child	$0
	• Additional - child prophylaxis, with or without fluoride (maximum of 2 additional per year)	$35
D1203	Topical application of fluoride (prophylaxis not included) - child	$0
D1204	Topical application of fluoride (prophylaxis not included) - adult	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1510	Space maintainer - fixed - unilateral	$65
D1515	Space maintainer - fixed - bilateral	$65
D1520	Space maintainer - removable - unilateral	$105
D1525	Space maintainer - removable - bilateral	$105
D1550	Re-cementation of space maintainer	$15
D1555	Removal of fixed space maintainer	$15
D2140	Amalgam - one surface, primary or permanent	$20
D2150	Amalgam - two surfaces, primary or permanent	$25
D2160	Amalgam - three surfaces, primary or permanent	$30

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

See Page 92 for a partial list of eligible expenses or visit FBMC's website at www.myFBMC.com for the full version of eligible expenses.

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

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

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

Endodontics — member pays

All procedures exclude final restoration

D3110	Pulp cap - direct (excluding final restoration)	$5
D3120	Pulp cap - indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40
D3221	Pulpal debridement, primary and permanent teeth	$60
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth(excluding final restoration)	$40
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth(excluding final restoration)	$40
D3310	Anterior (excluding final restoration)	$200
D3320	Bicuspid (excluding final restoration)	$210
D3330	Molar (excluding final restoration)	$310
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$110
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy – anterior	$230
D3347	Retreatment of previous root canal therapy – bicuspid	$280
D3348	Retreatment of previous root canal therapy – molar	$325
D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$70
D3352	Apexification/recalcification - interim visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$70

D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$70
D3410	Apicoectomy/periradicular surgery – anterior	$190
D3421	Apicoectomy/periradicular surgery - bicuspid (1st root)	$95
D3425	Apicoectomy/periradicular surgery - molar (1st root)	$95
D3426	Apicoectomy/periradicular surgery (each additional root)	$80
D3430	Retrograde filling - per root	$60
D3450	Root amputation - per root	$110
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal) not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15

Periodontics — member pays

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

Removable Prosthodontics — member pays

Includes up to 3 adjustments within 6 months of delivery.

D5110	Complete denture – maxillary	$375
D5120	Complete denture - mandibular	$375
D5130	Immediate denture - maxillary	$375
D5140	Immediate denture - mandibular	$375
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$375
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$375
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$375
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$375
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$480
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$480
D5281	Removable unilateral partial denture - one piece cast metal(including clasps and teeth)	$360
D5410	Adjust complete denture – maxillary	$20
D5411	Adjust complete denture – mandibular	$20
D5421	Adjust partial denture – maxillary	$20
D5422	Adjust partial denture – mandibular	$20
D5510	Repair broken complete denture base	$30
D5520	Replace missing or broken teeth - complete denture (each tooth)	$30
D5610	Repair resin denture base	$30
D5620	Repair cast framework	$50
D5630	Repair or replace broken clasp	$30
D5640	Replace broken teeth - per tooth	$30
D5650	Add tooth to existing partial denture	$45
D5660	Add clasp to existing partial denture	$70
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$125

D5711	Rebase complete mandibular denture	$125
D5720	Rebase maxillary partial denture	$125
D5721	Rebase mandibular partial denture	$125
D5730	Reline complete maxillary denture (chairside)	$65
D5731	Reline complete mandibular denture (chairside)	$65
D5740	Reline maxillary partial denture (chairside)	$65
D5741	Reline mandibular partial denture (chairside)	$65
D5750	Reline complete maxillary denture (laboratory)	$50
D5751	Reline complete mandibular denture (laboratory)	$50
D5760	Reline maxillary partial denture (laboratory)	$50
D5761	Reline mandibular partial denture (laboratory)	$50
D5810	Interim complete denture (maxillary)	$230
D5811	Interim complete denture (mandibular)	$230
D5820	Interim partial denture (maxillary)	$160
D5821	Interim partial denture (mandibular)	$170
D5850	Tissue conditioning, maxillary	$40
D5851	Tissue conditioning, mandibular	$40
D5862	Precision attachment, by report	$160

Crowns/Fixed Bridges - Per Unit — member pays

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

D6210	Pontic - cast high noble metal	$370
D6211	Pontic - cast predominantly base metal	$370
D6212	Pontic - cast noble metal	$370
D6214	Pontic - titanium	$370
D6240	Pontic - porcelain fused to high noble metal	$370
D6241	Pontic - porcelain fused to predominantly base metal	$370
D6242	Pontic - porcelain fused to noble metal	$370
D6245	Pontic - porcelain/ceramic	$370
D6250	Pontic - resin with high noble metal	$370
D6251	Pontic - resin with predominantly base metal	$370
D6252	Pontic - resin with noble metal	$370
D6253	Provisional pontic	$0
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$370
D6600	Inlay - porcelain/ceramic, two surfaces	$370
D6601	Inlay - porcelain/ceramic, three or more surfaces	$370
D6602	Inlay - cast high noble metal, two surfaces	$370
D6603	Inlay - cast high noble metal, three or more surfaces	$370
D6604	Inlay - cast predominantly base metal, two surfaces	$370
D6605	Inlay - cast predominantly base metal, three or more surfaces	$370
D6606	Inlay - cast noble metal, two surfaces	$370
D6607	Inlay - cast noble metal, three or more surfaces	$370
D6608	Onlay - porcelain/ceramic, two surfaces	$370
D6609	Onlay - porcelain/ceramic, three or more surfaces	$370
D6610	Onlay - cast high noble metal, two surfaces	$370
D6611	Onlay - cast high noble metal, three or more surfaces	$370
D6612	Onlay - cast predominantly base metal, two surfaces	$370
D6613	Onlay - cast predominantly base metal, three or more surfaces	$370
D6614	Onlay - cast noble metal, two surfaces	$370
D6615	Onlay - cast noble metal, three or more surfaces	$370
D6710	Crown - indirect resin based composite	$370
D6720	Crown - resin with high noble metal	$370
D6721	Crown - resin with predominantly base metal	$370
D6722	Crown - resin with noble metal	$370
D6740	Crown - porcelain/ceramic	$370
D6750	Crown - porcelain fused to high noble metal	$370
D6751	Crown - porcelain fused to predominantly base metal	$370
D6752	Crown - porcelain fused to noble metal	$370
D6780	Crown - 3/4 cast high noble metal	$370
D6781	Crown - 3/4 cast predominantly base metal	$370
D6782	Crown - 3/4 cast noble metal	$370
D6783	Crown - 3/4 porcelain/ceramic	$370
D6790	Crown - full cast high noble metal	$370
D6791	Crown - full cast predominantly base metal	$370
D6792	Crown - full cast noble metal	$370
D6794	Crown - titanium	$370
D6930	Recement fixed partial denture	$15
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6970	Cast post and core in addition to fixed partial denture retainer	$50
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$30
D6973	Core build up for retainer, including any pins	$10
D6976	Each additional cast post - same tooth	$40
D6977	Each additional prefabricated post - same tooth	$40
D6980	Fixed partial denture repair, by report	$45

Oral Surgery — member pays

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

D7111	Extraction, coronal remnants - deciduous tooth	$20
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$20
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth - soft tissue	$75
D7230	Removal of impacted tooth - partially bony	$85
D7240	Removal of impacted tooth - completely bony	$135
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$150
D7250	Surgical removal of residual tooth roots (cutting procedure)	$65
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$80

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D7280	Surgical access of an impacted unerupted tooth	$100
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Biopsy of oral tissue - hard (bone, tooth)	$150
D7286	Biopsy of oral tissue - soft	$60
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$50
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$45
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$100
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess - intraoral soft tissue	$35
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$35
D7520	Incision and drainage of abscess - extraoral soft tissue	$35
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$35
D7910	Suture of recent small wounds up to 5 cm	$25
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$90
D7963	Frenuloplasty	$90
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of pericoronal gingival	$40

Orthodontics — member pays

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

D8010	Limited orthodontic treatment of the primary dentition	$1,095
D8020	Limited orthodontic treatment of the transitional dentition	$1,095
D8030	Limited orthodontic treatment of the adolescent dentition	$1,095
D8040	Limited orthodontic treatment of the adult dentition	$1,095
D8050	Interceptive orthodontic treatment of the primary dentition	25% Discount
D8060	Interceptive orthodontic treatment of the transitional dentition	25% Discount
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,095
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,095
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,095
D8210	Removable appliance therapy	25% Discount
D8220	Fixed appliance therapy	25% Discount
D8660	Pre-orthodontic treatment visit	$35
D8670	Periodic orthodontic treatment visit (as part of contract)	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0
	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250
	Orthodontic visits beyond 24 months of active treatment or retention	$25 per visit

Adjunctive General Services — member pays

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

SafeGuard Standard DHMO Plan

SafeGuard, a MetLife Insurance Company

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

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

Plan Provider: SafeGuard, a Metropolitan Life Insurance Company.

SafeGuard Standard DHMO Plan

	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
Employee	$5.30	$4.42	$4.08
Employee & Family	$13.50	$11.25	$10.38

SafeGuard Standard DHMO Plan

SafeGuard, a MetLife Insurance Company

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

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

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

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

SafeGuard High DHMO Plan - SGC1034

Schedule of Benefits

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

Radiographs / Diagnostic Imaging		member pays
D0210	Intraoral - complete series (including bitewings)	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0273	Bitewings- three films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	Panoramic film	$0
D0350	Oral/facial photographic images	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjuctive pre-diagnostic test that aids in detection of mucosal abnormalties including premalignant and malignant lesions, not to include cytology or biopsy procedure	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0

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

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA.
See Page 92 for a partial list of eligible expenses or visit FBMC's website at www.myFBMC.com for the full version of eligible expenses.

D1555	Removal of fixed space maintainer	$5
D2140	Amalgam - one surface, primary or permanent	$0
D2150	Amalgam - two surfaces, primary or permanent	$0
D2160	Amalgam - three surfaces, primary or permanent	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$0
D2330	Resin-based composite - one surface, anterior	$35
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$50
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$55
D2390	Resin-based composite crown, anterior	$70
D2391	Resin-based composite - one surface, posterior	$60
D2392	Resin-based composite - two surfaces, posterior	$80
D2393	Resin-based composite - three surfaces, posterior	$90
D2394	Resin-based composite - four or more surfaces, posterior	$120

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

D2510	Inlay - metallic - one surface	$95
D2520	Inlay - metallic - two surfaces	$105
D2530	Inlay - metallic - three or more surfaces	$130
D2542	Onlay - metallic - two surfaces	$230
D2543	Onlay - metallic - three surfaces	$230
D2544	Onlay - metallic - four or more surfaces	$230
D2610	Inlay - porcelain/ceramic - one surface	$230
D2620	Inlay - porcelain/ceramic - two surfaces	$230
D2630	Inlay - porcelain/ceramic - three or more surfaces	$230
D2642	Onlay - porcelain/ceramic - two surfaces	$230
D2643	Onlay - porcelain/ceramic - three surfaces	$230
D2644	Onlay - porcelain/ceramic - four or more surfaces	$230
D2650	Inlay - resin-based composite - one surface	$230
D2651	Inlay - resin-based composite - two surfaces	$230
D2652	Inlay - resin-based composite - three or more surfaces	$230
D2662	Onlay - resin-based composite - two surfaces	$230
D2663	Onlay - resin-based composite - three surfaces	$230
D2664	Onlay - resin-based composite - four or more surfaces	$230
D2710	Crown - resin-based composite (indirect)	$230
D2712	Crown - 3/4 resin-based composite (indirect)	$230
D2720	Crown - resin with high noble metal	$230
D2721	Crown - resin with predominantly base metal	$230
D2722	Crown - resin with noble metal	$230
D2740	Crown - porcelain/ceramic substrate	$280
D2750	Crown - porcelain fused to high noble metal	$280
D2751	Crown - porcelain fused to predominantly base metal	$280
D2752	Crown - porcelain fused to noble metal	$280
D2780	Crown - 3/4 cast high noble metal	$230
D2781	Crown - 3/4 cast predominantly base metal	$230
D2782	Crown - 3/4 cast noble metal	$230
D2783	Crown - 3/4 porcelain/ceramic	$230
D2790	Crown - full cast high noble metal	$280
D2791	Crown - full cast predominantly base metal	$280
D2792	Crown - full cast noble metal	$280
D2794	Crown – titanium	$230
D2799	Provisional crown	$0
D2910	Recement inlay, onlay, or partial coverage restoration	$10
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$10
D2930	Prefabricated stainless steel crown - primary tooth	$25
D2931	Prefabricated stainless steel crown - permanent tooth	$25
D2932	Prefabricated resin crown	$35
D2933	Prefabricated stainless steel crown with resin window	$35
D2940	Sedative filling	$10
D2950	Core build up, including any pins	$45
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Cast post and core in addition to crown	$60
D2953	Each additional cast post - same tooth	$60
D2954	Prefabricated post and core in addition to crown	$60
D2955	Post removal (not in conjunction with endodontic therapy)	$10
D2957	Each additional prefabricated post - same tooth	$30
D2960	Labial veneer (resin laminate) - chairside	$250
D2961	Labial veneer (resin laminate) - laboratory	$300
D2962	Labial veneer (porcelain laminate) - laboratory	$350
D2970	Temporary crown (fractured tooth)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$50
D2980	Crown repair, by report	$0
	All procedures exclude final restoration	
D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$10
D3221	Pulpal debridement, primary and permanent teeth	$45
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	$30
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration)	$35
D3310	Anterior (excluding final restoration)	$80
D3320	Bicuspid (excluding final restoration)	$115
D3330	Molar (excluding final restoration)	$200
D3331	Treatment of root canal obstruction; non-surgical access	$85
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70
D3333	Internal root repair of perforation defects	$85
D3346	Retreatment of previous root canal therapy – anterior	$135
D3347	Retreatment of previous root canal therapy – bicuspid	$175
D3348	Retreatment of previous root canal therapy – molar	$275

D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$65
D3352	Apexification/recalcification - interim visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$65
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3410	Apicoectomy/periradicular surgery – anterior	$95
D3421	Apicoectomy/periradicular surgery - bicuspid (1st root)	$95
D3425	Apicoectomy/periradicular surgery - molar (1st root)	$95
D3426	Apicoectomy/periradicular surgery (each additional root)	$60
D3430	Retrograde filling - per root	$40
D3450	Root amputation - per root	$95
D3910	Surgical procedure for isolation of tooth with rubber dam	$19
D3920	Hemisection (including any root removal) not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$125
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$40
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$150
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$113
D4245	Apically positioned flap	$165
D4249	Clinical crown lengthening - hard tissue	$120
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$295
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$210
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$95
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95
D4266	Guided tissue regeneration - resorbable barrier, per site	$215
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$255
D4270	Pedicle soft tissue graft procedure	$245
D4271	Free soft tissue graft procedure (including donor site surgery)	$245
D4273	Subephithelial connective tissue graft procedure, per tooth	$75
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4275	Soft tissue allograft	$380
D4320	Provisional splinting – intracoronal	$95
D4321	Provisional splinting – extracoronal	$85
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$40
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$45
D4910	Periodontal maintenance	$30
	• Additional periodontal maintenance procedures (beyond 2 per 12 months)	$55
	• Periodontal charting for planning treatment of periodontal disease	$0
	• Periodontal hygiene instruction Includes up to 3 adjustments within 6 months of delivery.	$0
D5110	Complete denture – maxillary	$210
D5120	Complete denture - mandibular	$210
D5130	Immediate denture - maxillary	$225
D5140	Immediate denture - mandibular	$225
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$240
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$240
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$260
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$260
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$250
D5410	Adjust complete denture – maxillary	$0
D5411	Adjust complete denture – mandibular	$0
D5421	Adjust partial denture – maxillary	$0
D5422	Adjust partial denture – mandibular	$0
D5510	Repair broken complete denture base	$15
D5520	Replace missing or broken teeth - complete denture (each tooth)	$15
D5610	Repair resin denture base	$15
D5620	Repair cast framework	$30
D5630	Repair or replace broken clasp	$15
D5640	Replace broken teeth - per tooth	$15
D5650	Add tooth to existing partial denture	$30
D5660	Add clasp to existing partial denture	$35
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165

D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$60
D5711	Rebase complete mandibular denture	$60
D5720	Rebase maxillary partial denture	$60
D5721	Rebase mandibular partial denture	$60
D5730	Reline complete maxillary denture (chairside)	$35
D5731	Reline complete mandibular denture (chairside)	$35
D5740	Reline maxillary partial denture (chairside	$35
D5741	Reline mandibular partial denture (chairside)	$35
D5750	Reline complete maxillary denture (laboratory)	$35
D5751	Reline complete mandibular denture (laboratory)	$35
D5760	Reline maxillary partial denture (laboratory)	$35
D5761	Reline mandibular partial denture (laboratory)	$35
D5810	Interim complete denture (maxillary)	$230
D5811	Interim complete denture (mandibular)	$230
D5820	Interim partial denture (maxillary)	$60
D5821	Interim partial denture (mandibular)	$60
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$160

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

D6210	Pontic - cast high noble metal	$280
D6211	Pontic - cast predominantly base metal	$280
D6212	Pontic - cast noble metal	$280
D6214	Pontic - titanium	$280
D6240	Pontic - porcelain fused to high noble metal	$280
D6241	Pontic - porcelain fused to predominantly base metal	$280
D6242	Pontic - porcelain fused to noble metal	$280
D6245	Pontic - porcelain/ceramic	$250
D6250	Pontic - resin with high noble metal	$230
D6251	Pontic - resin with predominantly base metal	$230
D6252	Pontic - resin with noble metal	$230
D6253	Provisional pontic	$0
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$200
D6600	Inlay - porcelain/ceramic, two surfaces	$230
D6601	Inlay - porcelain/ceramic, three or more surfaces	$230
D6602	Inlay - cast high noble metal, two surfaces	$230
D6603	Inlay - cast high noble metal, three or more surfaces	$230
D6604	Inlay - cast predominantly base metal, two surfaces	$230
D6605	Inlay - cast predominantly base metal, three or more surfaces	$230
D6606	Inlay - cast noble metal, two surfaces	$230
D6607	Inlay - cast noble metal, three or more surfaces	$230
D6608	Onlay - porcelain/ceramic, two surfaces	$230
D6609	Onlay - porcelain/ceramic, three or more surfaces	$230
D6610	Onlay - cast high noble metal, two surfaces	$230
D6611	Onlay - cast high noble metal, three or more surfaces	$230
D6612	Onlay - cast predominantly base metal, two surfaces	$230
D6613	Onlay - cast predominantly base metal, three or more surfaces	$230
D6614	Onlay - cast noble metal, two surfaces	$230
D6615	Onlay - cast noble metal, three or more surfaces	$230
D6710	Crown - indirect resin based composite	$230
D6720	Crown - resin with high noble metal	$230
D6721	Crown - resin with predominantly base metal	$230
D6722	Crown - resin with noble metal	$230
D6740	Crown - porcelain/ceramic	$230
D6750	Crown - porcelain fused to high noble metal	$230
D6751	Crown - porcelain fused to predominantly base metal	$230
D6752	Crown - porcelain fused to noble metal	$230
D6780	Crown - 3/4 cast high noble metal	$230
D6781	Crown - 3/4 cast predominantly base metal	$230
D6782	Crown - 3/4 cast noble metal	$230
D6783	Crown - 3/4 porcelain/ceramic	$230
D6790	Crown - full cast high noble metal	$230
D6791	Crown - full cast predominantly base metal	$230
D6792	Crown - full cast noble metal	$230
D6794	Crown - titanium	$230
D6930	Recement fixed partial denture	$0
D6940	Stress breaker	$110
D6950	Precision attachment	$195
D6970	Cast post and core in addition to fixed partial denture retainer	$50
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$30
D6973	Core build up for retainer, including any pins	$10
D6976	Each additional cast post - same tooth	$40
D6977	Each additional prefabricated post - same tooth	$40
D6980	Fixed partial denture repair, by report	$45

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

D7111	Extraction, coronal remnants - deciduous tooth	$0
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$30
D7220	Removal of impacted tooth - soft tissue	$45
D7230	Removal of impacted tooth - partially bony	$65
D7240	Removal of impacted tooth - completely bony	$80
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$100
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50
D7280	Surgical access of an impacted unerupted tooth	$85
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$90
D7283	Placement of device to facilitate eruption of impacted tooth	$90
D7285	Biopsy of oral tissue - hard (bone, tooth)	$0
D7286	Biopsy of oral tissue - soft	$0
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$50
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$35
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$25
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$70
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7471	Removal of lateral exostosis (maxilla or mandible)	$80
D7472	Removal of torus palatinus	$60
D7473	Removal of torus mandibularis	$60
D7485	Surgical reduction of osseous tuberosity	$60
D7510	Incision and drainage of abscess - intraoral soft tissue	$25
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30
D7520	Incision and drainage of abscess - extraoral soft tissue	$30
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30
D7910	Suture of recent small wounds up to 5 cm	$25
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$40
D7963	Frenuloplasty	$40
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of pericoronal gingival	$35
	• Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.	
	• Comprehensive orthodontic benefits include all phases of treatment and fixed/removable appliances.	
D8010	Limited orthodontic treatment of the primary dentition	$1,000
D8020	Limited orthodontic treatment of the transitional dentition	$1,000
D8030	Limited orthodontic treatment of the adolescent dentition	$1,000
D8040	Limited orthodontic treatment of the adult dentition	$1,000
D8050	Interceptive orthodontic treatment of the primary dentition	25% Discount
D8060	Interceptive orthodontic treatment of the transitional dentition	25% Discount
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,800
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,800
D8210	Removable appliance therapy	25% Discount
D8220	Fixed appliance therapy	25% Discount
D8660	Pre-orthodontic treatment visit	$0
D8670	Periodic orthodontic treatment visit (as part of contract)	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0
	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$250
	Orthodontic visits beyond 24 months of active treatment or retention	$25 per visit
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10
D9120	Fixed partial denture sectioning	$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9220	Deep sedation/general anesthesia - first 30 minutes	$150
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$150
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$45
D9248	Non-intravenous conscious sedation	$15
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$0
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$30
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic drug injection, by report	$15
D9612	Therapeutic parental drugs, two or more administrations, different medications	$25
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$85
D9942	Repair and/or reline of occlusal guard	$40
D9951	Occlusal adjustment - limited	$25
D9952	Occlusal adjustment - complete	$100
D9972	External bleaching - per arch	$125
	• Broken appointment (less than 24 hour notice) Not to exceed	$25

SafeGuard High DHMO Plan

SafeGuard, a MetLife Insurance Company

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

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

Plan Provider: SafeGuard, a Metropolitan Life Insurance Company.

SafeGuard High DHMO Plans

	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
Employee	$7.49	$6.25	$5.76
Employee & Family	$19.13	$15.74	$14.71

Dental Terminology Definitions

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

Amalgam: A silver filling

Anterior: Teeth that are in the front of the mouth

Bicuspid: Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.

Bridge: A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).

Crown: A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.

Endodontics: Procedures that treat the nerve or the pulp of the tooth due to injury or infection.

Oral Surgery: Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics: Braces and other procedures to straighten the teeth.

Periodontics: Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).

Posterior: Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).

Primary Teeth: The first set of teeth ("baby" teeth).

Prophylaxis: Scaling and polishing of teeth by removal of the plaque above the gum line.

Prosthodontics: The restoration of natural and/or the replacement of missing teeth with artificial substitutes.

Quadrant: One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).

Resin-based Composite: Tooth-colored (white) fillings.

General Exclusions

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

Limitations:

General

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

Preventive:

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

Diagnostic:

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

Restorative:

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

Prosthodontics:

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

Endodontics:

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

Oral Surgery:

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

Orthodontic Exclusions and Limitations:

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

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

How to use dental benefits:

A list containing the Select Panel Providers in Miami-Dade, Broward, Monroe and Palm Beach Counties can be viewed online at **www.metlife.com/mybenefits.** You may call the SafeGuard Customer Services Department at 1.800.880.1800 to verify your dentist's continued participation in your selected plan.

SafeGuard Dental Plans

How can I make an appointment with my SafeGuard dentist?

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

Who is an eligible dependent for this coverage?

Eligible dependents for this plan include:

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

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

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

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

What if I need the services of a Specialist?

During the course of treatment, your selected General Dentist may recommend the services of a dental specialist. Your selected general dentist will refer you directly to a contracted SafeGuard specialty care provider; no additional referral or pre-authorization from SafeGuard is required. You may also call customer service at 800.880.1800 to get a list of specialists in your area.

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

You may request a second opinion if you have unanswered questions about diagnosis, treatment plans and/or the results achieved by such dental treatment. Contact SafeGuard Customer Service at 800.880.1800 or your selected General Dentist may request a second opinion on your behalf. Such requests are processed within five (5) business days of receipt, except when an expedited second opinion is warranted. Upon approval, SafeGuard will contact the consulting dentist and make arrangements to enable you to schedule an appointment. The fee for a second opinion consultation is $5.

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

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

How can I receive Emergency Care within the service area?

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

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to the SafeGuard Member Services Department at Miami-Dade: 305.995.7029 or toll-free: 800.880.1800. Representatives are available Monday - Friday, 8 a.m. - 6 p.m., ET.

MetLife Indemnity Dental Plan

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

	STANDARD PLAN		HIGH PLAN	
	In-Network South Florida (Area 3)†	Out-of-Network	In-Network South Florida (Area 3)†	Out-of-Network
ANNUAL CALENDAR YEAR DEDUCTIBLE Deductible applies to	None N/A	$50/person $150/ family (type A,B,C)	$50/ person $150/ family (type B,C)	$50/ person $150/ family (type A,B,C)
ANNUAL CALENDAR YEAR MAXIMUM Maximum benefit allowed per person for Types A, B & C Combined	$1500	$1500	$1500	$1500
PREVENTIVE (Type A) X-rays (bitewing 2 per year) X-rays (full mouth or panoramic every 3 years) Cleaning and scaling (2 per year) Fluoride treatment (up to age 19 - one per year)	EMPLOYEE PAYS $0 $0 $15 $0	PLAN PAYS 90% of PDP fees** 90% of PDP fees** 90% of PDP fees** 90% of PDP fees**	PLAN PAYS 100% of PDP fees* 100% of PDP fees* 100% of PDP fees* 100% of PDP fees*	PLAN PAYS 100% of PDP fees** 100% of PDP fees** 100% of PDP fees** 100% of PDP fees**
BASIC SERVICE (Type B) Space Maintainers - unilateral (up to age 19) Sealants (Dependent child up to age 19 - once every 5 years on permanent molars only) Amalgams (2 surfaces) Periodontics maintenance (4 per calender year)	$105 $15 $45 $40	60% of PDP fees** 60% of PDP fees** 60% of PDP fees** 60% of PDP fees**	100% of PDP fees* 100% of PDP fees* 80% of PDP fees* 80% of PDP fees* 80% of PDP fees*	100% of PDP fees** 100% of PDP fees** 80% of PDP fees** 80% of PDP fees** 80% of PDP fees**
MAJOR SERVICE (Type C) Denture relining (chairside) Denture adjustments General anesthesia (30 minutes) Impacted Teeth Periodontics (gum treatment) scaling and root planning Crowns Bridges Full dentures Partial dentures resin base Inlays Onlays Simple extractions Additional extraction Surgical extractions Root canal therapy Anterior Bicuspid Molar Repairs to prosthetics	$105 $30 $155 $145 $85 per quad $475 $435 $535 $420 $330 $475 $50 $50 $105 $300 $355 $490 $80	30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees** 30% of PDP fees**	50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees* 50% of PDP fees*	50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees** 50% of PDP fees**
ORTHODONTIA (Type D) Amount	 $2,100***	50% of PDP fees** $1500/person	50% of PDP fees* $1500/person	50% of PDP fees** $1500/person

† South Florida (Area 3) consists of zip codes that begin with the digits 330, 331, 333, 334, 339, 340, 349, 320-329, 335-338, 341-348. If you do not reside in a zip code that begins with these digits, please contact MetLife at 1.800.942.0854 for a more accurate in-network schedule of benefits and fees.

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

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

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

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

See Page 92 for a partial list of eligible expenses or visit FBMC's website at www.myFBMC.com for the full version of eligible expenses.

MetLife Indemnity Dental Plan

Your Rates are listed below.

MetLife Dental Plan Rates (per pay period)

Standard Indemnity	10-month	11-month	12-month
Employee	10.38	$8.65	$7.98
Employee & Family	$31.84	$26.54	$24.49
High Indemnity	**10-month**	**11-month**	**12-month**
Employee	$21.68	$18.07	$16.68
Employee & Family	$64.83	$54.03	$49.87

Limitations

Type A (Preventive & Diagnostic)

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

Type B (Operative & Restorative)

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

Type C (Prosthodontics)

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

Type D (Orthodontics)

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

Exclusions

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

Continuation of Exclusions

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

How to select the MetLife Dental Plans

Employee-Paid Benefits:

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

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

About the MetLife Dental Plans

Pre-determination of benefits:

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

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

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

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

Visit **www.metlife.com/mybenefits** for a PDP listing of the participating dentists in the South Florida area. To find a participating dentist in your area, call 1.800.474.PDP1 (7371), Monday-Friday, 6 a.m-11 p.m. (ET), and Saturday, 7 a.m. – 4 p.m. (ET). Input the information as requested and a customized PDP directory will be mailed to you.

How can I make an appointment with my dentist?

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

Where can I get MetLife Dental Plan claim forms?

Dental claim forms will be provided to you upon request at the Office of Risk and Benefits Management. For claims assistance or status, log on to **www.metlife.com/mybenefits** or call MetLife's Customer Service at 1.800.942.0854.

To access the provider directory, log on to www.dadeschools.net or you may contact the provider at 800.942.0854.

MetLife Indemnity Dental Plan

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to Metropolitan Life Insurance Company Customer Service at 1.800.942.0854.

Who is an eligible dependent for this coverage?

Eligible dependents for this plan include:

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

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

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

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

In-Network (PDP)	
Preferred Dentist's Fee	$62.60
Plan pays 80% of PDP Fee	- $50.08
You pay 20% of PDP Fee	$12.52
Your Cost	$12.52*

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

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

* Example assumes $50 deductible has been satisfied.

** Example assumes $150 deductible has been satisfied.

Plan Provider: Metropolitan Life Insurance Company.

Plan Provider: Metropolitan Life Insurance Company.

Vision Plan

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

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

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

Schedule of Benefits

Covered services*	In-network	out-of-network
One-Time Co-Payment	$10	N/A
(Applies to frames and/or lenses, contact lens fitting and follow up)		
Vision Exam (once every 12 months)	Paid in full	up to $40
Single Lenses (once every 12 months)	Paid in full**	up to $40
Bifocal Lenses (once every 12 months)	Paid in full**	up to $60
Trifocal Lenses (once every 12 months)	Paid in full**	up to $80
Frames	Paid in full Private Practice: Private Practice: 100% coverage after $10 co-pay ($130 allowance) Retail Chain: 100% coverage after $10 co-pay ($130 allowance)	up to $45
Frequency	one a year	one a year
Contact lenses (in lieu of frames and lenses)		
Elected by Insured	Paid in full or up to $105 allowance	up to $105
Medically Necessary	Paid in full or up to $175 allowance	up to $175

Mail Order Contact Replacement	10% provider discount
Optional Services at Additional Costs (for Panel Plan only)	
	You Pay
Solid Tint	$13
Gradient Tint	$15
Ultra Violet Coating (Glass)	$23
Standard Scratch Resistance Coating	$0
Anti-Reflection Coating	$40
Glass PGX	
Single Vision	$32
Multifocal	$47

* During any plan year, you may elect either the frames and/or lenses covered service or the contact lenses allowance, but not both.

** Single vision, lined bifocal or lined trifocal are paid in full.

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA.
See Page 92 for a partial list of eligible expenses or visit FBMC's website at **www.myFBMC.com** for the full version of eligible expenses.

Vision Plan

Notes on the UnitedHealthcare Vision In-Network:

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

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

Using a Panel Eye Doctor

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

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

1. You are responsible for payment of the entire fee. There will be a one-time reimbursement by the UnitedHealthcare Vision Plan up to the amounts listed on page 20.
2. The vision exam is provided once every plan year, with a maximum $40 reimbursement.
3. Lenses are provided once every 12 months, if needed, as determined by your optometrist or ophthalmologist.
4. Frames are provided every 12 months, if needed. Frames are limited to a maximum $45 benefit.
5. Contact lenses will be provided once every 12 months under the plan, if needed, as determined by your optometrist or ophthalmologist. Payment will be made for only one pair of lenses, either single, bifocal, trifocal, or contacts during a plan year. No frame or lens benefits are available during the plan year that contact lenses are elected.

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

1. UnitedHealthcare Vision Out-of-Network vision benefits are valid at any non-panel licensed ophthalmologist, optometrist or optician.
2. Vision claim forms will be provided upon request by **UnitedHealthcare Vision at 1.800.638.3120.**

Can you explain the UnitedHealthcare Vision Plan frame benefits?

Under the UnitedHealthcare plan, you are free to choose any frame available at any provider location, or any frame that a provider is willing to order for you. At both network retail locations and private locations, you will receive a $130 retail allowance toward the cost of the frame. If the frame falls within the allowance, it will be fully covered with no out-of-pocket expenses beyond the material co-pay. If you choose a frame that exceeds these allowances, you only pay the difference and may also take advantage of any provider discounts offered.

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

What services and materials does the plan exclude?

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

UnitedHealthcare Vision Plan

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

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA. Refer to Page 92 for more details.

Visit www.myFBMC.com for a full list of eligible expenses.

Vision Plan

Who is an eligible dependent for this coverage?

Eligible dependents covered under this plan include:

- Spouse/Domestic Partner
- Children (including children of a Domestic Partner, as long as the Domestic Partner is also covered) will be covered under this plan until the end of the calendar year in which he/she reaches age 26. Coverage applies whether they are/are not married or a student.

How to select UnitedHealthcare Vision Plan benefits:

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

Plan Provider:

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

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

To access the provider directory, log on to www.dadeschools.net or you may contact UnitedHealthcare at 1.800.638.3120.

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

Identity Theft Plan

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

What is identity theft?

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

How We Protect You

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

Monitoring

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

Step 1 - Verification

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

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

Step 2 - Identity Profile Report Page

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

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

Step 3 - Monthly Monitoring

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

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

Detection

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

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

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

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

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

Identity Theft Plan

Resolution

Should your ID SnapShot reveal any indication that you have been a victim of identity theft, we will work on your behalf to clear your name through our unique ID Rehab™ process. Our resolution experts will negotiate with any applicable institutions, file the necessary paperwork, and follow up to see that your good name is restored. This restoration is provided, free of charge, to ID Watchdog Plus customers who encounter issues while enrolled in the program, and is backed by our 100% resolution guarantee. ID Watchdog ensures you'll never have to worry about cleaning up the damage that can come from a breached identity.

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

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

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

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

Take Control with Online Account Access

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

If you need additional support, you can call us with your questions at 1.800.970.5182. Our Customer Service is available: Monday - Friday 8 a.m. - 6 p.m. (MST).

Who is an eligible dependent covered under this plan?

Eligible dependents covered under the this plan include:

- Spouse (until a final decree of divorced has been filed)
- Domestic Partner
- Unmarried natural children, stepchildren, children under your care through court-approved guardianship, and children of a Domestic Partner through the end of the calendar year in which he/she reaches age 20.
- Children may be covered until the end of the calendar year in which the child reaches age 26 if he/she is a full-time or part-time student who receives more than half of his/her financial support from the eligible employee. Children may also be covered until the end of the calendar year in which he/she reaches age 26 if the child suffers from a mental or physical handicap, is incapable of self-support, and is fully dependent upon the employee for support.

Your individual plan rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
ID Theft Plan (Employee-only)	$ 4.77	$ 3.98	$ 3.67
ID Theft Plan (Family)	$8.97	$7.48	$6.90

What is ID Watchdog?

ID Watchdog was created in 2004 by a group of seasoned credit professionals who recognized the growing crime of identity theft and sought out to provide un-matched protection services to consumers. By enlisting experts on all facets of identity theft – including law enforcement authorities, judicial representatives, consumer privacy advocates and banking and credit experts – ID Watchdog created the most powerful, pro-consumer identity theft protection product possible. ID Watchdog is a publicly traded company on the Toronto Stock Exchange, under the symbol (IDW. V.)

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

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

ARAG Legal Plan

Legal Plan Coverage

Administered by ARAG, the legal plan is a legal safety net that provides comprehensive legal protection and resources. The legal plan includes:

- No waiting periods on ANY coverages (including bankruptcy and divorce). You can use the plan as soon as you need it.
- Broad coverage of life's legal issues. More coverages for your investment including defense of motions to modify, administrative hearings and IRS audit protection and collection defense.
- Freedom of choice for representation. You can choose ANY attorney you want to work with, in or outside ARAG's Network. ARAG doesn't assign attorneys for representation.
- A trusted carrier with national reach. As a leading provider of legal insurance in the United States for more that 35 years, you have access to ARAG's ~~its~~ nationwide network of more than 6,600 attorneys.

You can use the ARAG Legal Plan as soon as you need to, NO waiting periods. Benefits include:

In-office Legal Representation

Attorney fees for most covered matters are 100% paid-in-full when you work with your choice of a Network Attorney with NO waiting periods unless otherwise stated. Network Attorneys provide legal representation – including review and document preparation – for covered legal matters including:

- Standard Will Preparation
- Complex Will Preparation (up to 6 office hours)
- Codicil Preparation (Amendment to a Will)
- Living Will Preparation
- Powers of Attorney Preparation
- Contested Guardianship/Conservatorship
- Uncontested Guardianship/Conservatorship
- Legal Name Change Proceedings
- Contested Divorce (up to 10 office Hours/$70 per hour for all additional hours)
- Uncontested Divorce
- Defense of Motions to Modify, a Final Divorce Decree
- Spousal Divorce (partial reimbursement)
- Consumer Protection
- Debt Collection Defense
- Juvenile Court Proceedings
- Defense of Felony (named insured only)
- Criminal Misdemeanor Defense
- Driving Privilege Protection
- Driving While Intoxicated
- Personal Transfers (1 purchase and sale per year)
- Refinance (up to 1 hour per year)
- Personal Property Issues
- Tenant Rental Issues
- Administrative Hearings (includes visa extensions, naturalization and deportation, also referred to as removal)
- Insanity and Infirmity Defense
- IRS Audit Protection (partial reimbursement)
- IRS Collection Defense (partial reimbursement)
- Personal Bankruptcy
- General In-Office for any other legal issues - (up to 2 hours per family every 6 months)

For a complete list, please review the chart on Page 128.

To locate a Network Attorney in your area, call the toll-free number, 1.800.360.5567, or visit ARAGLegalCenter.com, enter Access Code: **10287mds, click on the "Choose Your Plan" tab and the Attorney Finder link.**

You can see a Network Attorney for legal representation – including review and document preparation.

You may also select a Non-Network Attorney and the plan will reimburse you according to scheduled limits. The legal services that are available are listed on the chart on Page 128.

Reduced Fee Services

If you need legal representation for a legal situation that's not covered under the ARAG Legal Plan, you can still save money through the Reduced Fee Benefit. Network Attorneys provide a reduced fee of at least 25 percent off their normal hourly rate for any legal situations that are not covered or excluded.

Telephone Legal Advice and Consultation

Attorneys can easily handle certain legal matters over the phone. You can consult with a Network Attorney over the phone as often as necessary – for any of the following legal needs, including:

- General Legal Advice and Consultation on virtually any legal matter
- Standard Will Preparation
- Living Will Preparation
- Durable Powers of Attorney Preparation
- Small Claims Assistance
- Follow-up Calls and Letters
- Specific Document Preparation
- Document Review

Identity Theft Services

You have toll-free access to Certified Identity Theft Case Managers who will help you get your life back in order and repair any damage done to your identity. The case managers will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain plan coverages that may be relevant to the identity theft, such as Consumer Protection
- Provide Identity Theft Prevention and Victim Action Kits
- Monitor the resolution of the situation

Immigration Assistance

To help with the immigration process, your plan includes:

- Toll-free telephone advice from an attorney on how immigration relates to your legal matter and what actions may be taken.
- Access to immigration education materials.
- Access to Network Attorneys who will provide reduced fee services of at least 25% off their normal hourly rate for specific covered matters.

ARAG Legal Plan

Online Legal Tools and Resources
The ARAG Legal Center provides easy online access to legal tools and resources, including:

- An Education Center offering a wide range of tools to educate and empower you to handle your legal issues, including the Law Guide, Guidebooks, LawExpresso and the Legal Glossary.
- Hundreds of Do-It-Yourself Legal Documents™, when you want the convenience and control of preparing legally valid documents yourself.
- Assessments, calculators, and profiles to learn what legal matters may impact your life.

Financial Education and Counseling Services - ARAG Exclusive

You have access to PricewaterhouseCoopers LLP professional Financial Counselors and ~~an~~ online resources exclusively through your ARAG Legal Plan. Experienced Financial Counselors are available to answer questions and provide guidance on a range of financial topics including:

- General Financial Planning Information and Guidance
- Cash and Debt Management/Budgeting
- Retirement and Investment Planning
- Federal Tax Information and Education
- Individual Retirement Accounts (IRAs)

You also have access to online resources through the ARAG Legal Center that provide:

- A Personalized Financial Plan
- A Step-by-Step Action Plan
- Life Events Guides and Financial Articles
- Online Courses
- Financial Calculators
- A Mutual Center
- Webcasts

What if I have a legal concern that existed before I became insured under the ARAG Legal Plan?

Coverage for pre-existing matters is included as long as the legal action or charge is filed and the attorney is first retained after the effective date of the policy. (Most attorneys' fees are 100 percent paid-in-full for covered matters when a Network Attorney is used.) Coverage is provided for matters in process at the time of termination of employment or plan termination. Coverage is provided anywhere in the United States.

Your rates are listed below.
NOTE: These premiums will be deducted on a post-tax basis.

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Legal Plan	$ 10.38	$ 8.65	$ 7.98

How to Use Legal Benefits

You can use your ARAG Legal Plan as soon as you need to, with NO waiting periods, in the following ways:

1. **Legal Advice and Consultation:** Insured employees can reach a Network Attorney by calling 1.800.360.5567, Monday - Friday, 8 a.m. - 8 p.m., ET.
2. **Legal Representation Services – Network Attorney:** Contact the Network Attorney of your choice and identify yourself as an insured M-DCPS employee and ARAG member. The Network Attorney will file a claim with ARAG to receive reimbursement and, for most covered benefits, attorney fees are 100 percent paid-in-full. You will be responsible for any filing fees, court costs and miscellaneous costs, such as photocopying.
3. **Legal Representation Services – Non-Network Attorney/Indemnity Coverage:** You may choose to use an attorney not in the network and be reimbursed by ARAG up to schedule maximums by submitting a claim form and your attorney's billing statement directly to ARAG. Claim forms can be obtained by calling the ARAG Customer Care Center at 1.800.360.5567, Monday - Friday, 8 a.m. - 8 p.m., ET or by logging in as a member at ARAGLegalCenter.com and clicking on the "Find an Attorney" tab and the "Non-Network Attorney Claim Form" link.

How to Select ARAG Legal Benefits

You may cover yourself and your family by selecting the ARAG Legal Plan under the Employee-Paid FlexPlan Benefits section of the online enrollment.

How does the legal coverage benefit affect taxes?

According to IRS rules, the Legal Plan is not qualified to be included in the FlexPlan as a tax-free benefit. If you select legal coverage, your premium is deducted on an after-tax basis (POST-TAX).

What legal services does the plan exclude?

Plan exclusions include: actions between you and your employer, union, fellow employees, WageWorks, insurance carriers, ARAG Insurance Company, or anyone else when prohibited by law; business matters, preparation of tax returns, patents or copyrights, summary procedure actions; class actions, interventions or amicus curiae filings, citizen's dispute settlements program procedures; filing fees, court costs, and miscellaneous costs, or matters where other reimbursement is available; contingency fee, workers' compensation, unemployment compensation and probate cases; actions between you and your dependents; duplication of services previously claimed, title search and title insurance, and legal proceedings where you are entitled to legal representation or reimbursement from any other source; and matters related to structural damage to dwellings, appurtenances, paved surfaces and matters not specifically listed.

Who is an eligible dependent covered under this plan?

Eligible dependents covered under the Legal Plan include:

- Spouse (until a final decree of divorced has been filed)
- Domestic Partner
- Unmarried natural children, stepchildren, children under your care through court-approved guardianship, and children of a Domestic Partner through the end of the calendar year in which he/she reaches age 19.
- Children may be covered until the end of the calendar year in which the child reaches age 26 if he/she is a full-time or part-time student who receives more than half of his/her financial support from the eligible employee. Children may also be covered until the end of the calendar year in which he/she reaches age 26 if the child suffers from a mental or physical handicap, is incapable of self-support, and is fully dependent upon the employee for support.

Which insurance company makes the Legal Plan available to me?

ARAG Insurance Company underwrites and administers the plan. A.M. Best's Reports, an organization that compares and rates the financial strength and performance of insurance companies, rates ARAG Insurance Company "A" (Excellent).

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

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

What legal services are available?

The chart below shows the legal services available.

Coverage	Network Attorney	Non-Network Attorney*
In-Office Legal Services		
Consumer protection	Paid in full	$2,200**
Debt Collection Defense		
IRS audit protection		
(attorney or accountant)		
Audit consultation	$420*	$420*
Representation at audit before litigation	$900*	$900*
Defense for IRS litigation	$5,000*	$5,000*
Personal bankruptcy/wage-earner plan	Paid in full	$420*
Dissolution		
Divorce, legal separation or annulment (coverage for employee)		
Uncontested	Paid in full	$600*
Contested		$600*
ARAG will pay a Network Attorney in full for the first 10 hours of the attorney's time. The Network Attorney will bill the insured at $70 per hour for all additional hours.		
Employee's Spouse's legal fees	$300*	$300*
Defense of motion to modify a prior divorce decree	Paid in full	$360*
Adoption	Paid in full	$350*
Contested Guardianship/Conservatorship		
Uncontested Guardianship/Conservatorship	Paid in full	$300*
Incompetency or infirmary proceedings	Paid in full	$2,200**
Name change	Paid in full	$240*
Juvenile court proceedings (excluding traffic matters)	Paid in full	$2,080**
Habeas corpus	Paid in full	$300*
Defense of DWI	Paid in full	$2,080**
Criminal misdemeanor defense (except involving motorized vehicles)	Paid in full	$2,080**
Traffic charges where your license could be suspended or revoked	Paid in full	$2,080**
Felony (named insured only)	Paid in full	$2,500*
Estate planning		
Individual simple will	Paid in full	$100
Husband and wife simple wills	Paid in full	$125
Codicil	Paid in full	$60*
Complex Wills (Wills with trust)	Paid in full 6 hrs.	$240*
Living will	Paid in full	$60*
Durable power of attorney	Paid in full	$60*
Purchase/sale of principal residence (one attempt at each per year)	Paid in full	$360*
Real estate refinancing (limit of one hour)	Paid in full	$60*
Administrative hearings (excluding employment related)	Paid in full	$1,200*
General In-office***		
Office consultations for legal advice, negotiation, document preparation and review	2 hours every 6 months per family, noncumulative***	$120*

Coverage continued	Network Attorney	Non-Network Attorney*
Telephone Legal Advice and Consultation	Paid in full	N/A

Attorneys can easily handle certain legal matters over the phone.
You can consult with a Network Attorney over the phone as often as necessary – for any of the following legal needs including:

- General Legal Advice and Consultation on virtually any legal matter
- Standard Will Preparation
- Living Will and Durable Powers of Attorney Preparation
- Small Claims Assistance
- Follow-up Calls and Letters
- Specific Document Preparation
- Document Review

ONLINE LEGAL Tools and resources – Paid in full	N/A	N/A

At ARAGLegalCenter.com, you have easy online access to legal services, including:

- Assessments, calculators, and profiles to learn what legal matters may impact your life.
- An Education Center offering a wide range of tools to educate and empower you to handle your legal issues, including:
  - Law Guide - easy-to-understand legal articles to help you research your legal situation.
  - Guidebooks - A collection of "go-to guides" with detailed information and checklists to assist you with common life events.
  - Legal Glossary - An easy-to-use glossary to help you better understand complex legal terms.
  - Hundreds of Do-It-Yourself Legal Documents™, for when you want the convenience and control of preparing legally valid documents yourself.

VALUE-ADDED SERVICES

• Financial and Education Counseling Services - Paid in Full	N/A	N/A
• Identity Theft Services - Paid in full	N/A	N/A
• Immigration Assistance - Paid in Full		

* Non-Network Attorney coverage is at $60 per hour to the stated amount for pre-trial; $200 for 1/2 day trial.

** Trial coverage of $1600 is included in these amounts ($200 for half-day trial, and major coverage). Pretrial coverage is the stated amount less $1600.

*** You cannot use the 2 hours to increase any other plan benefits or waive their limitations.

ARAG SeniorAdvocate™

ARAG SeniorAdvocate™ Legal Plan
M-DCPS offers a one-stop resource with the legal, financial and adult care assistance you need to take care of your family: SeniorAdvocate Legal Plan, administered by ARAG.

With SeniorAdvocate, you can receive legal advice and consultation, and reduced fee services on a variety of legal matters including: fraud, schemes and scams, planning for incapacity, healthcare decisions, financial planning, debt and consumer protection and estate planning.

Which of my family members can benefit from the SeniorAdvocate™ Plan?

You can use the plan for matters related to your parents, grandparents, spouse's parents and spouse's grandparents.

What legal services are offered?

Legal Advice and Consultation
You will have toll-free telephone access to a Network Attorney for the following services:

- Legal Advice and Consultation - Toll-free telephone advice on how the law relates to senior family members personal legal matters and which actions may be taken.
- Document Preparation - Assistance with the preparation or review of the following documents as they relate to the senior family members:
  - Special powers of attorney and revocations
  - Challenge to denial of credit
  - Bad check notice
  - Promissory notes and affidavits related to their personal property
  - Bills of sale related to personal property
- Document Review - Attorneys will review legal documents for the senior family member, up to four pages, except those related to trusts or real estate property transfers.
- Follow-up Calls/Correspondence - Assistance with follow-up telephone calls and correspondence to third parties, related to the senior family member.

Legal Representation
If a matter requires an in-office visit, you can meet with a Network Attorney and you are guaranteed at least a reduced fee of at least 25 percent off of his/her normal rates.

To use a Network Attorney:

- Contact the attorney to make an appointment. Identify yourself as an ARAG plan member.
- Ask the attorney what materials you should bring to your appointment.
- The attorney will provide the needed services.
- The Network Attorney will bill you directly at the discounted rate.

What Financial Educational and Counseling Services are available?

Only through ARAG's SeniorAdvocate do you have exclusive access to professional financial counselors from PricewaterhouseCoopers LLP and an interactive financial planning website to help you deal with your senior family members financial future.

Experienced financial counselors are available to answer questions and provide guidance on a range of financial topics including:

- General Financial Planning Information and Guidance
- Cash and Debt Management/Budgeting
- Retirement and Investment Planning
- Federal Tax Information and Education
- Individual Retirement Accounts (IRAs)

You also have access to an interactive financial planning website that offers:

- A Personalized Financial Plan
- A Step-by-Step Action Plan
- Life Events Guides and Financial Articles
- Online Courses
- Financial Calculators
- A Mutual Center
- Webcasts

Identity Theft Services

You have toll-free access to Certified Identity Theft Case Managers who will help your senior family members get their life back in order and repair any damage done to their identity. The case managers will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain relevant plan coverages
- Provide Identity Theft Prevention and Victim Action Kits
- Monitor the resolution of the situation

To access the provider directory, visit ARAGLegalCenter.com, enter Access Code: 10287mds, click on the "Choose Your Plan" tab and the Attorney Finder link.

For questions relating to your account, contact a Customer Care Specialist at 800.360.5567, Monday - Friday, between 8 a.m. - 8 p.m. ET.

ARAG SeniorAdvocate™

What are Caregiving Services?

You can receive assistance in planning for your own or your senior family member's immediate or future adult care needs through toll-free, telephone access to a Care Advocate who will:

- Answer your eldercare-related questions, assess eldercare needs and help you develop a care plan.
- Send you a customized information guide that contains lists of assisted living facilities, nursing homes or home health care agencies – including comparative quality-of-care ratings and reports on thousands of facilities and agencies – along with helpful eldercare information.
- Give you access to the nation's most comprehensive eldercare database with more than 90,000 long-term care providers.
- Conduct searches to determine availability and rates of assisted living facilities, nursing homes, home health care agencies and adult day care providers. Advocate will negotiate discounts when available.

Plus, you will have access to the **ElderAnswers Website** which provides you online access to quality-of-care ratings and reports, direct access to the provider database, and a wide-range of eldercare information.

Which insurance company makes the SeniorAdvocate Legal Plan available to me?

ARAG Insurance Company underwrites and administers this plan. A.M. Best's Reports, an organization that compares and rates the financial strength and performance of insurance companies, rates ARAG Insurance Company "A" (Excellent).

Visit **ARAGLegalCenter.com and enter Access Code: 10287mds for more information.**

Your rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
SeniorAdvocate™ Program	$4.66	$3.88	$3.58

Life the Way You Want to Live™

For your convenience, attorney information and an online Attorney Finder can be found when you visit ARAGLegalCenter.com, enter Access Code: 10287mds, click on the "Choose Your Plan" tab and the Attorney Finder link. You may also call the Customer Care Center at **1.800.360.5567**, Monday - Friday, 8 a.m. – 8 p.m. ET. The ARAG Network Attorneys average nearly 25 years of experience.

Is your personal attorney a member of the ARAG Attorney Network? If not, let them know and they can contact ARAG about joining, or the attorney can visit **www.ARAGgroup.com.**

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

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

For questions relating to your account, contact a Customer Care Specialist at 1.800.360.5567, Monday - Friday, between 8 a.m. - 8 p.m. ET.

US Legal Family Defender

Legal Plan Coverage

The Family Defender covers employees and their dependents and provides legal services from Network and Non-Network Attorneys. The Family Defender covers employees and their dependents and provides legal services from Network and Non-Network Attorneys.

In-Office Legal Representation

Most of the following benefits are 100% paid-in-full for attorneys' fees when you use a Network Attorney.

- Simple Will
- Complex Will
- Codicil
- Living Will
- Power of Attorney
- Guardianship/Conservatorship
- Name Change
- Divorce
- Child Support
- Post Judgment Decree
- Post Decree Modification
- Consumer Protection
- Consumer Debt Collection
- Juvenile Proceedings
- Criminal Misdemeanor
- Immigration
- Driving Privilege Protection
- Personal Property Issues
- Tenant Rental Issues
- IRS Audit Protection
- IRS Collection Defense
- Real Estate
- Estate Administration
- Expungements

To locate a Network Attorney in your area, call the toll-free telephone number 800.356.LAWS or visit:**http://home.uslegalservices.net/M-DCPS.**

You can see a local Network Attorney for legal representation – including review and document preparation.

You may select a Non-Network Attorney and the plan will reimburse you according to scheduled limits. The legal services available are listed on the chart on Page 134.

Reduced Fee Services

If you need legal representation for a legal situation that's not covered under The Family Defender, but not specifically excluded, you can still save money by using a Network Attorney at a reduced fee of at least 33 1/3% percent off their normal hourly rate for legal matters.

Telephone Legal Advice

Attorneys can easily handle certain issues over the phone. You can consult with a Network Attorney over the phone as often as necessary for virtually any personal legal need, including:

- General Legal Advice
- Will Preparation
- Living Will Preparation
- Durable Powers of Attorney Preparation
- Small Claims Assistance
- Follow-up calls and letters
- Specific Document Preparation
- Document Review

Immigration Coverage

- Visa Extensions: Defined as application for extension of any existing visas where eligible for said extensions.
- Naturalization: Defined as advice, consultation, preparation and filing of applications for naturalization before the United States Bureau of Citizenship and Immigration Services.
- Deportation (Now known as Removal): Advice, consultation and appearance before the U.S. Immigration Court to provide members with Defense of Removal actions and/or applications for Relief from Removal before the Immigration Judge.

Legal Tools and Resources

You have easy online access to legal services, including:

- An extensive law guide of articles on everyday legal topics
- Do-it-yourself personal legal documents
- Attorney Locator
- Other education information

Identity Theft Services

As a member, you have access to a highly trained Fraud Resolution Specialist who will conduct seven emergency response activities, including:

- Assisting members with restoring their identity and good credit
- Provide members with a free "ID Theft Emergency Response Kit"
- Assists with disputes of fraudulent debts, as a result of ID theft
- Counsels and provides a document stating the "Preventative Steps" to avoid future ID theft losses and damages

Personal Financial and Tax Planning Services

The financial coaching benefit provides access to "Financial Coaches" with a broad range of experience in financial services, including licensed CPA's and Certified Financial Planners. Our Coaches are salaried professionals who do not sell or promote products and services to our members. The financial benefit allows families an opportunity to determine the most appropriate way to handle their financial problems or issues by talking with an expert.

US Legal Family Defender

What about legal matters that occurred before I became insured under the U.S. Legal Plan?

Coverage for pre-existing matters is included as long as the legal action is filed and the attorney is first retained after the effective date of the policy. (Most attorneys' fees are paid-in-full for covered matters when a Network Attorney is used.) Coverage is provided for matters in process at the time of termination of employment or plan termination. Coverage is provided anywhere in the United States. Further required legal services may be obtained for a 1/3 discount.

How to Use Legal Benefits

1. Legal Advice and Consultation: Insured employees can reach a Telephone Network Attorney by calling 1.800.356.LAWS, 24/7.
2. In-office Legal Representation Services Network Attorney: Contact an attorney and identify yourself as an insured M-DCPS employee and U.S. Legal member. The local Network Attorney will file a claim with U.S. Legal to receive reimbursement and, for most covered benefits, attorney fees are paid-in-full. You will be responsible for any filing fees, court costs and miscellaneous costs.
3. In office Legal Representation Services Non-Network Attorney/ Indemnity Coverage: You may use any non- Network Attorney and be reimbursed by U.S. LEGAL up to schedule maximums by submitting a claim form and your attorney's billing statement directly to U.S. LEGAL. Claim forms can be obtained by calling the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262), Monday Friday, 7 a.m.- 8 p.m., ET or by logging into the U.S. LEGAL Website at **www.uslprotects.com/member/familyprotector/mdcps**

How to Select Legal Benefits

You may cover yourself and your family by selecting U.S. Legal under the Employee-Paid FlexPlan Benefits section of the online enrollment.

How does the legal coverage benefit affect taxes?

According to IRS rules, the Legal Plan is not qualified to be included in the FlexPlan as a tax-free benefit. If you select legal coverage, your premium is deducted on an after-tax basis (POST-TAX).

What legal services does the plan exclude?

Actions between you and your employer, union, fellow employees, WageWorks, insurance carriers, U.S. LEGAL Insurance Company, or anyone else when prohibited by law; business matters, preparation of tax returns, patents or copyrights, summary procedure actions; class actions, interventions or amicus curiae filings, citizen's dispute settlements program procedures; filing fees, court costs, and miscellaneous costs, or matters where other reimbursement is available; contingency fee, workers' compensation, unemployment compensation and probate cases; actions between you and your dependents; duplication of services previously claimed, title search and title insurance, and legal proceedings where you are entitled to legal representation or reimbursement from any other source; and matter related to structural damage to dwellings, appurtenances, paved surfaces and matters not specifically listed.

Your US Legal rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Family Defender	$10.14	$8.45	$7.80

Who is an eligible dependent covered under this plan?

Eligible dependents covered under the Legal Plan include:

- Spouse (until a final decree of divorced has been filed)
- Domestic Partner
- Unmarried natural children, stepchildren, children under your care through court approved guardianship, and children of a Domestic Partner through the end of the calendar year in which he/she reaches age 19.
- Children may be covered until the end of the calendar year in which the child reaches age 26 if he/she is a full-time or part-time student who receives more than half of his/her financial support from the eligible employee. Children may also be covered until the end of the calendar year in which he/she reaches age 26 if the child suffers from a mental or physical handicap, is incapable of self-support, and is fully dependent upon the employee for support.

Which insurance company makes the Legal Plan available to me?

U.S. Legal Services, Inc. underwrites and administers the Family Defender Legal Plan. The Family Defender is recognized nationally by consumer groups as one of the broadest and most comprehensive legal plans in the industry.

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

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

US Legal Senior Defender

What Legal services are available?

The chart below shows the legal services available:

COVERAGE	NETWORK ATTORNEY	NON-NETWORK ATTORNEY*
In-Office Legal Services		
Consumer Protection Action		
Including Small Claims Court	Paid-in-Full	$2,200**
IRS Audit Protection (attorney or accountant)		
Consultation	$420*	$420*
Representation at audit before litigation	$900*	$900*
Defense for IRS litigation	$5,000*	$5,000*
Personal bankruptcy/wage earner plan	Paid-in-Full	$500*
Dissolution		
Divorce, separation or annulment (coverage for employee)		
Uncontested	Paid-in-Full	$600*
Contested	15 hours paid in full per calendar Year, Network Attorney will bill $70 per hour thereafter	$600*
Employee's Spouses legal fees	$300*	$300*
Defense of Post Decree issues	15 hours paid in full per calendar Year, Network Attorney will bill $70 per hour thereafter	$600*
Adoption	Paid-in-Full	$350*
Guardianship/Conservatorship	Paid-in-Full	$300*
Incompetency or infirmary proceedings	Paid-in-Full	$2,200**
Name Change	Paid-in-Full	$250*
Juvenile Court (excluding Traffic)	Paid-in-Full	$2,100*
Habeas Corpus	Paid-in-Full	$300*
Defense of DUI	Paid-in-Full	$2,100**
Criminal Misdemeanor (excluding Traffic)	Paid-in-Full	$2,100**
Traffic charges where your license could be suspended or revoked	Paid-in-Full	$2,100**
Felony (named insured only)	Paid-in-Full	$2,500**
Estate Planning		
Individual Simple Wills	Paid-in-Full	$100
Husband and Wife	Paid-in-Full	$125
Codicil	Paid-in-Full	$60
Wills with Trust	Paid-in-Full	$240
Living Will	Paid-in-Full	$60
Durable Power of Attorney	Paid-in-Full	$60
Purchase sale of primary residence	Paid-in-Full	$360*
Real Estate Refinancing	Paid-in-Full	$60*
Administrative Hearings (excluding employment related)	Paid-in-Full	$1,200*
Preventative Law	Paid-in-Full	$120
Immigration	Paid-in-Full	$420*
Estate Administration	Paid-in-Full	$420*
Business Law	Paid-in-Full	$60
Expungement	Paid-in-Full	$240
In-Office Legal Services		
Online Tools and Resources	N/A	
• Law Guide of articles of everyday legal topics		
• Do-it-yourself personal legal documents		
• Attorney search		
• Other educational material		
Value-Added Services		
• Financial Planning and Tax Advice Paid-in-Full		
• Identity Theft Services		

* Non-Network Attorney coverage is $60 per hour to the stated amount for pre-trial; $200 for ½ day trial

**Trial coverage of $1600 is included in these amounts ($200 for one-half day trial and major coverage) Pre-trial is the stated amount less $1600

US Legal Senior Defender

Senior Defender

Elder Law attorneys will assist you with the many legal and other issues which confront seniors and retirees and parents of our members. Elder law attorneys can advise you on the laws in your state and assist you in all the coverage areas of Part I. Elder Law Attorneys could also be of assistance if your net worth or your asset structure is unusually complex. Your legal plan has contracted with this sector of the bar in anticipation of your specific needs in this area of law.

Which of my family members can benefit from the Senior Defender Plan?

If you are buying the plan to help care for senior family members, you can use the plan for matters related only to your parents, grandparents, spouse's parents and spouse's grandparents.

What legal services are offered?

Legal Advice and Consultation

- Telephone Legal Access Services
- Telephone Legal Assistance with preparation of documents
- Elder Fraud and Schemes
- Planning for Incapacity
- Health Care decisions
- Financial Planning
- Debt and Consumer Counseling
- Estate Planning, Wills, Trusts and Living Trusts
- Medicare and Private Health Insurance
- Medicaid

Legal Representation

If a matter requires an in-office visit, you can meet with a Network Attorney and you are guaranteed a reduced fee of at least 33 1/3% off the attorney's normal hourly rates.

To use a Network Attorney:

- Call into U.S. Legal's toll-free number, 800.356.LAWS, and tell the CSR you need an attorney for a Senior Defender Issue. The CSR will assign you an attorney with experience in the area of your legal issue.
- Contact the attorney to make an appointment. Identify yourself as an U.S. Legal member.
- Ask the attorney what material you should bring to your appointment.
- The attorney will provide the needed services.
- The Network Attorney will bill you directly at the discounted rate.

What Financial Tax Planning Services are available?

With personal financial counseling, members have access to:

- Toll-free, confidential telephone access to an experienced financial planner
- One-on-one counseling – with no sales pitches
- Planners who are familiar with all areas of financial planning
- Assistance in integrating all resources into an overall financial plan
- Personalized reports on topics such as Investment for Retirement, Asset Allocation and College Funding.

Your US Legal rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Senior Defender	$4.65	$3.88	$3.58

Identity Theft Services

You will have toll-free access to an Identity Theft Case Manager who will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain relevant plan coverage
- Monitor and follow-up on the situation

What are the Independent Living services?

You can receive assistance in planning for your own or your senior family member's immediate or future adult care needs through toll-free, telephone access from Adult Care Specialists. They can assist plan members in matters relating to:

- Nursing homes
- Home health care
- Long distance caregiving
- Emergency and respite care
- Discharge planning
- Residential care
- Housing options
- Senior centers
- Caregiver issues and concerns
- Adult daycare
- Long-term care insurance
- Transportation services
- Medicare and Medicaid
- Social Security
- Community services
- Funeral planning
- Grief and bereavement
- Hospice services
- Meal delivery programs

Adult Care Specialists conduct a comprehensive intake and needs assessment with plan members. Once the specialist has fully assessed your needs, you will be provided with a basic overview of the types of providers and resources available.

Which insurance company makes the Legal Plan available to me?

U.S. Legal Services, Inc. underwrites and administers the Family Defender Legal Plan. The Family Defender is recognized nationally by consumer groups as one of the broadest and most comprehensive legal plans in the industry.

US Legal Senior Defender

Client Organizer and Checklist

By virtue of becoming a member of this plan you are entitled to receive a Client Organizer and Checklist. This document has been prepared for your use by attorneys who specialize in Elder law and Taxation. The areas of Elder law and Taxation cover a wide variety of issues that older Americans and their children must deal with and will serve as a quick reference by you of the foregoing summary of areas of the law that you are entitled to consult. This Organizer has been designed to achieve maximum efficiency. The Organizer is divided into general areas of law so as to be of its best help to you in evaluating your own circumstances and at the same time readily and efficiently allows you to be able to give to your attorney the information that he or she will need to advise you as best as is possible.

When you receive the Organizer, please familiarize yourself with its contents and make arrangements to keep it permanently secured in a safe place where you would normally keep your other important records. This Organizer is best utilized prior to calling the attorney. When you need to discuss a problem or matter with your attorney, please refer to your Organizer and to the general area of concern that is reflected in the table of contents of the Organizer. Please review the questions therein and be prepared to give those answers to your attorney when you call.

Will & Trust Planner

Your membership in this plan also entitles you at no cost to receive a free Will & Trust Planner. This document has been prepared by our attorneys and will enable you to decide if you need a will or trust, or, whether you need to update or change an existing will or trust.

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

www.uslprotects.com/members/family-protector/mdcps
1.800.356.LAWS

Short-Term Disability (STD)

The Miami-Dade County School Board provides all eligible, full-time employees with Standard Short-Term Disability (STD). This Standard STD plan provides a benefit of 60 percent of your earnings up to a maximum of $500 per week. Benefits under this plan are paid up to 22 weeks after a 30 calendar day elimination period. You may elect to upgrade this plan by purchasing one of the upgrade plans available.

What is Short-Term Disability?

STD provides you with income, it protects your paycheck by paying you 60% of your earnings when you are out of work due to short periods of disability due to injury or illness, as defined in the policy. Loss of income can be devastating – and today, it's more important than ever for employees and their families to understand how they would manage their regular expenses during a period of lost income and make sure they're prepared.

What STD plans are available to purchase?

You may elect to buy up to one of the voluntary options below:

Standard Upgrade: This plan upgrades your Standard STD plan by paying benefits 2 weeks longer, to 24 weeks ~~and~~ by reducing the elimination period from 30 to 15 calendar days. It continues to pay 60% of your earnings to a maximum of $500 a week.

High: This plan is designed for employees with salaries in excess of $43,000 annually. It continues to pay 60% of earnings but increases the maximum benefit payable from $500 to $1000. The 30 day elimination period and 22 week benefit remain the same as the STD Standard plan.

High Upgrade: This plan is also designed for employees with salaries in excess of $43,000 annually. It provides a 24 week benefit period after a 15 calendar day elimination period, while providing a benefit of 60 percent of your earnings up to a maximum of $1,000 week.

When can I begin collecting benefits?

Depending on the STD plan you have, the:

Standard and High Plans - Benefits are paid up to 22 weeks after a 30 calendar day elimination period.

Standard Upgrade and High Upgrade Plans - Benefits are paid up to 24 weeks after a 15 calendar day elimination period.

Am I eligible for disability benefits after childbirth?

Yes, if you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the eight weeks. If you have vaginal birth, you will be considered disabled for a minimum of six weeks beginning on the date of your vaginal delivery, unless you return to work prior to the end of the six weeks.

Your rates are listed below.

	10-MONTH	11-MONTH	12-MONTH
Upgrade from Board-Paid Standard to Standard Upgrade	$3.28	$2.74	$2.52
High	$1.21	$1.01	$.93
High Upgrade	$5.29	$4.41	$4.07

Example: You have a standard STD plan and have a C-section on January 29, 2013. Your waiting period is from January 29, 2013, through February 7, 2013. Your Standard STD benefit begins on February 8, 2013, for four weeks.

What services does this benefit include? What is deducted from my STD benefit payments?

What does it cover? Life's unexpected curve balls: A back injury, for instance. Or a serious illness. Or the birth of twins. Depending on how much protection you choose, your STD plan delivers a percentage of your income every week. And beyond your monthly benefits, it offers expert help: Services from legal specialists, financial experts and therapeutic counselors to ease the stress and boost your confidence. To prevent over insurance, The Hartford will subtract from your gross disability payment other sources of income (see your certificate for a definition of other sources of income, if any). You do not have to use up your sick days to receive benefits. However, if you do choose to use your sick days, The Hartford will NOT subtract from the gross disability payment income you receive from salary continuation or sick leave plan.

When should I submit a claim?

Your claim should be submitted within 30 days after the date of your disability begins or as soon as possible. However, The Hartford must receive written proof of your claim no later than 90 days after your elimination period. If this is not possible, proof must be given no later than one year after the time proof is required except in the absence of legal capacity.

How do I submit a claim?

You must initiate your claim by calling The Hartford's toll-free telephonic claim intake number at 1.800.741.4306 and report your claim. You will not need to submit a paper claim form as the The Hartford intake specialist will take your information by phone. However, it will be your responsibility to provide an authorization form to your physician to be signed/dated and faxed or mailed to The Hartford. This allows The Hartford to access your medical records in order to process your claim.

Is there a survivor benefit?

No. There is no survivor benefit included with this Short-Term Disability plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that affect any benefits payable. For complete details of coverage and availability, please contact The Hartford at 305.995.4889.

Short-Term Disability (STD)

What is the minimum weekly benefit?

The minimum weekly benefit is $25.

What are the exclusions?

The policy will not cover any disability due to:

- War or act of war (declared or not)
- Military service for any country engaged in war or other armed conflict
- The commission of, or attempt to commit a felony
- An intentional self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Any injury sustained as a result of doing any work for pay or profit for another employer
- Occupational sickness or injury covered by workers' compensation
- Elective cosmetic surgery

Are benefits taxable?

If your premiums to upgrade to the High plan are paid on a pre-tax basis, you will receive a W-2 form for the calendar year in which benefits were paid. However, if your premiums were paid on a post-tax basis, benefits paid to you will not be taxed. The premiums paid by the School Board for the Standard Disability plan will be on a pre-tax basis.

Am I eligible for benefits under this plan if I am absent from work on the plan effective date?

No. If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

What insurance company makes this plan available to me?

The Short-Term Disability benefit is offered through Hartford Life and Accident Insurance Company. The Hartford is rated "A, (Excellent)" rating effective 2012) by A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies.

Is Coverage guaranteed during this enrollment?

Full-Time New Hires: Yes. You have the opportunity to enroll in Short-Term Disability during this enrollment period without submitting Evidence of Insurability. If you are currently eligible for coverage, but choose not to elect a plan option greater than the Standard STD plan upgrade during this enrollment, future enrollments will require that you complete Evidence of Insurability and your coverage will not be guaranteed.

Part-Time New Hires: You are eligible to enroll for Short-Term Disability within 31 days of 1st becoming eligible without submitting Evidence of Insurability.

Current Employees: No. If you are a current full-time or part-time employee who chose not to enroll previously in Long-Term Disability or one of the Short-Term Disability buy up plans, **you must now complete an Evidence of Insurability (EOI) form before you are considered for coverage.** Existing employees currently enrolled in one of the Short-term buy up plans or Long-term plans and not making changes during this enrollment will continue with their current coverage. New hires do not need to provide EOI. Current employees electing this benefit during the 2013 Open Enrollment must complete an EOI form which will be verified by The Hartford. If your buy up or LTD EOI is approved, the effective date of this benefit will be the first of the month following your first payroll deduction.

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

EOI forms will be distributed by The Hartford. For any questions regarding EOI you may call Customer Service 1.800.331.7234. You may call a Hartford Representative at 1.800.741.4306.

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

Long-Term Disability (LTD)

The Long-Term Disability Plan will provide you with 60 percent of your income if you are totally disabled and qualify for benefits. Total disability is the inability to perform one or more essential duties of your regular occupation and you have a 20 percent or more loss in your monthly earnings. After 24 months of payments, you are disabled when The Hartford determines that you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Am I eligible for benefits under this plan if I am absent from work on the plan effective date?

No. If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

What are the amounts of Long-Term Disability benefits available?

You can choose the level of coverage that best suits your needs. They are as follows:

Level 1: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $1,800

Level 2: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $3,000

Level 3: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $5,000

Level 4: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $7,500

Benefits are reduced by any benefits received from other sources, as defined on Page 141. A person currently disabled will not be eligible to increase their benefit.

How to Select Your Level of Coverage

You should consider your annual salary when selecting a level of coverage to provide you and your family the most protection.

If your annual salary is less than $36,000, you should select Level 1 Coverage.

If your annual salary is $36,000 - $60,000, you should select Level 2 Coverage.

If your annual salary is $60,000 - $100,000, you should select Level 3 Coverage.

If your annual salary is greater than $100,000, you should select Level 4 Coverage.

What is the minimum benefit?

The minimum monthly benefit is $100, or 10 percent of your gross disability benefit, whichever is greater.

How long must I be totally disabled before I receive benefits?

There is a 180 elimination period (benefit waiting period), during which time you must be continuously disabled and for which no benefit is payable. The elimination period begins on the first day of disability. You can satisfy your elimination period if you are working, as long as you meet the definition of disability. Your disability may be treated as continuous as long as you do not exceed 90 return-to-work days during the elimination period.

When are benefits payable?

LTD benefits begin to accrue after you meet the definition of disability as defined in the policy to satisfy a benefit waiting period of 180 days or the expiration of accrued sick leave, whichever is greater.

How long are benefits payable?

If you are disabled prior to age 62, your benefits will cover you to age 67. If you are disabled at age 62 or after, benefits will be paid according to a decreasing maximum benefit period as indicated below:

Age at Disability	Maximum Benefit Period
Less than age 62	to age 67
62	60 months
63	48 months
64	42 months
65	36 months
66	30 months
67	24 months
68	18 months
69 and over	12 months

Is coverage guaranteed during this enrollment?

New Hires: Yes. You have the opportunity to enroll in Long-Term Disability during this enrollment period without submitting Evidence of Insurability. If you are currently eligible for coverage, but choose not to enroll during this enrollment, future enrollments will require that you complete Evidence of Insurability and your coverage will not be guaranteed.

Current Employees: No. If you chose not to enroll during previous enrollments, you must now complete an Evidence of Insurability (EOI) form before you are considered for coverage. The effective date of increased amount will be the first of the month following approval and first deduction. Your current premium will continue until the upgrades are applied for the new plan year. Your Long-Term Disability will not become effective until the first of the month following approval by The Hartford.

EOI forms will be distributed by The Hartford. For any questions, you may call a representative at 305.995.4889.

Long-Term Disability (LTD)

Must I pay my premiums if my disability prevents me from working?

Your LTD premium payments are waived when you begin receiving LTD benefit checks. Premiums for all levels of LTD coverage are 100 percent employee paid.

What limitations apply for Mental Illness?

The monthly benefit payments for disabilities due to sickness or injury, which are due to mental illness, will not exceed 24 months. However, any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 months.

What benefits are included in Long-Term Disability?

If you become disabled, the following benefits can help until you get back to full-time work.

Work Incentive Benefit - This benefit offers an effective incentive if you are disabled and return to work. You may receive your full disability benefit during the first 12 months after returning, as long as your benefit and earnings are not more than 100 percent of pre-disability earnings.

Rehabilitation and Return to Work Assistance - The Hartford vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help you return to productive, independent lifestyles.

Worksite Modification Benefit - The Hartford helps your employer make the worksite accommodations necessary to enable employees to return to work. This benefit reimburses your employer up to the amount equal to the amount of the maximum monthly benefit for worksite modifications for each employee.

Family Care Credit Benefit - When you are disabled and incurring child care expenses for your dependent child(ren) and participating continuously in the Rehabilitation and Return to Work Assistance program, The Hartford will, for the purpose of calculating your benefit, deduct the cost of family care from earnings received from work as part of a program of Rehabilitation, subject to limitations. The reimbursement payment will begin immediately after you start the Rehabilitation and Return to Work Program.

The child must be under 13 years of age or incapable of providing their own care on a daily basis due to their own physical handicap or mental retardation.

Worldwide Emergency Assistance Services

Worldwide Assistance

Just one phone call gives employees and their families 24-hour access to a network of emergency medical and legal resources any time they travel more than 100 miles from home.

The Hartford's Travel Assistance Program is provided by Worldwide Assistance, a Europe Assistance company and part of the world's leading assistance network.

The program provides three kinds of services for your business or vacation travel - Pre Trip Information, Emergency Medical Assistance, and Emergency Personal Services subject to terms and conditions of the policy. Of course, all our travel services are simple to take advantage of from start to finish.

Pre Trip Planning includes:

- Visa, Passport, inoculation and Immunization Requirements
- International “Hot Spots”
- Travel Advisories
- Foreign Exchange Rates
- Embassy and Consular Referrals

Emergency Medical Assistance includes:

- Medical Referrals, Medical Monitoring, and Medical Evacuation
- Repatriation
- Traveling Companion and Dependent Children Assistance
- Emergency Medical Payments
- Return of Mortal Remains
- Replacement of Medication and Eyeglasses

Emergency Personal Services includes:

- Sending and Receiving Emergency Messages
- Emergency Travel Arrangements
- Emergency Cash
- Locating Lost Items
- Legal Assistance
- Bail Advancement
- Translation

What is a recurrent disability?

A recurrent disability is a disability that is related to, or due to the same cause or causes of a prior disability for which a monthly benefit was paid. A recurrent disability will be treated as part of the prior disability and you will not have to complete another elimination period if, after receiving disability benefits under the plan, an employee returns to work on a full-time basis for less than six months and performs all of the duties of the employee's own occupation. Benefit payments will be subject to the terms of the plan for the prior disability.

What are the limitations?

The policy will not cover any disability due to:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Military service for any country engaged in war or other armed conflict

Are benefits taxable?

Because your premiums are paid on a post-tax basis, disability benefits paid to you will not be taxed.

Long-Term Disability (LTD)

When should I submit a claim?

Your claim should be submitted within 30 days after the date of your disability begins or as soon as possible. However, The Hartford must receive written proof of your claim no later than 90 days after your elimination period. If this is not possible, proof must be given no later than one year after the time proof is required except in the absence of legal capacity.

How do I submit a claim?

The transition process from Short Term Disability to Long Term Disability claim is automated by our claim system. A claimant questionnaire is sent to the employee that requests information about other income/offset information, past work experience/education and medical providers. We may also obtain additional information from the employer. A separate claim form is not required.

What if I receive benefits from another group disability plan or other source?

Disability benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)

Disability benefit payments will not be reduced by certain kinds of other income, such as:

- Retirement benefits if you were already receiving them before you became disabled
- Retirement benefits that are funded by your after-tax contributions
- The portion of your Long Term Disability payment that you place in an IRS-approved account to fund your future retirement.
- Your personal savings, investments, IRAs or Keoghs
- Profit-sharing
- Most personal disability policies
- Social Security increases

Is there a survivor benefit?

Yes, if you die after your disability had continued for 180 or more consecutive days; and you were receiving or were entitled to receive payments under the plan, The Hartford will pay your eligible survivor a lump sum benefit equal to three months of your gross disability payment.

Is there a pre-existing condition clause?

Yes. Your insurance limits the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your policy, you will be covered for a disability due to that condition only if:

- You have not received treatment for your condition for three months before the effective date of your insurance, or
- You have been insured under this coverage for twelve months prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
- You have already satisfied the pre-existing condition requirement of your previous insurer.

Your rates are listed below.

All premiums are on a post-tax basis.

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Level 1	$14.48	$12.07	$11.14
Level 2	$18.56	$15.47	$14.28
Level 3	$27.98	$23.32	$21.52
Level 4	For Level 4 coverage (available only if your salary is in excess of $100,000), determine your premium by choosing a payroll cycle and following ONE of the formulas below:		

For 10-MONTH (20 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06 ÷ 20 = $_____

For 11-MONTH (24 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06. ÷ 24 = $_____

For 12-MONTH (26 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06 ÷ 26 = $_____

* If your salary exceeds $150,000, enter $150,000 here.

What insurance company makes this plan available?

The Long-Term Disability benefit is offered through Hartford Life and Accident Insurance Company. The Hartford is rated "A (Excellent)" (rating effective 2012) by A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies.

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Hospital Indemnity Coverage

Hospital Indemnity Coverage provides benefits if you or your insured dependents are confined in a hospital as an inpatient. The levels of daily coverage are $50, $100 or $150. The Employee-Paid daily benefit levels combined cannot exceed $150. You must be enrolled for coverage in order to enroll your dependent(s). Coverage for your dependents cannot exceed your own.

If a child is born to anyone under this policy while family coverage is in force, the child shall automatically become a covered dependent from the moment of birth. However, you must still contact the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262) and request a Change in Status form. This includes coverage for sickness or injury, and the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. Routine care for the child is not covered under this policy.

You and your dependents may select different levels of coverage as long as (a) your amount does not exceed $150 and (b) your dependent's level of coverage does not exceed your own.

Who is an eligible dependent for this coverage?

Eligible dependents covered under this plan include:

- Legal Spouse/Domestic Partner
- Unmarried children who are under age 25 provided:
  - the child is dependent upon the insured for support
  - the child is living in the insured's household, or
  - the child is a full-time or part-time student.

NOTE: 'Child' includes stepchild, legally adopted child, a child pending finalization of adoption proceedings, natural child, and children of a Domestic Partner (provided the Domestic Partner is also covered). Dependent eligibility will be determined at the time of claim.

When will my benefit payments start?

You are eligible for benefits on the first day of a covered hospitalization.

How long will the benefits continue?

These benefits are payable for each day you are confined as an inpatient in a covered hospital (see exclusions) for any period from one to 365 days. Successive periods of hospital confinement, due to the same or related causes, not separated by 60 days shall be considered as one period of hospital confinement.

Must I still pay my premiums if I am hospitalized or disabled and unable to work?

If you are confined in a hospital before your 60th birthday, coverage will be continued without further payment of premiums:

a) after you have received benefits for 60 consecutive days during which premiums are paid, and
b) while you remain in the hospital as an inpatient for the same or related injury or sickness and benefits continue to be paid to a maximum of 365 days.

If you become disabled before your 60th birthday, coverage will be continued without further payment of premiums after you have been disabled for nine (9) straight months during which premiums were paid. Premiums will continue to be waived as long as you remain hospitalized or disabled provided you are eligible to continue receiving benefits, but no more than 365 days.

Waiver of Premium applies only to you; however, coverage for your covered dependents will also be continued without further payments while premiums are waived.

When are benefits payable?

Benefits are payable for each day of a necessary hospital confinement when the insured is confined in a hospital as an inpatient as recommended by a doctor for care that is reasonably and medically necessary.

How do I obtain claim forms?

To obtain claim forms, call the FBMC Service Center at 1-855-5MYFBMC (1-855-569-3262), Monday - Friday, 7 a.m. - 8 p.m. (ET).

Are benefits taxable?

The IRS may require you to pay taxes on payments you receive from the Hospital Indemnity Coverage plan under current law. For further information, consult your personal tax advisor.

Definitions

"Doctor" means a duly licensed practitioner of the healing arts acting within the scope of his/her license. Doctor does not include: the Insured or the Insured's spouse; or the Insured or the Insured spouse's child, parent, brother, sister; or a person living with the Insured.

"Hospital" means an institution which:

a) is licensed as a hospital pursuant to applicable law;
b) is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
c) is under the supervision of a staff of doctors
d) provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.)
e) has medical, diagnostic and treatment facilities, with major surgical facilities:
   1) on its premises, or
   2) available to it on a prearranged basis, and
f) charges for its services.

Is there a survivor benefit?

Yes, if benefits are unpaid at the time of your death, one lump sum payment will be made to the first surviving class of the following classes of persons:

- wife or husband
- child(ren)
- mother or father
- sister or brother

If there is no surviving member as stated above, the benefits will be paid

Hospital Indemnity Coverage

to the Insured's estate.

What injuries or sicknesses are excluded from coverage?

Benefits will not be paid for a loss caused by or resulting from:

- Intentionally self-inflicted injuries
- Voluntary self-administration of any drug or chemical substance not prescribed by, or taken according to the directions of a doctor (accidental ingestion of a poisonous substance is not excluded)
- Driving while intoxicated or driving under the influence of a controlled substance unless administered on the advice of a doctor
- Commission or attempt to commit a felony
- Participation in a riot or insurrection
- Declared or undeclared war or act of war
- Active duty service in any armed forces (proof of service will result in a refund of premium; reserve or national guard active duty or training is not excluded unless it extends beyond 31 days)
- Elective or cosmetic surgery (unrelated to trauma, infection or other disease of the involved part, or congenital disease or anomaly of a covered dependent child, which resulted in a functional defect)
- Dental surgery, unless the surgery is the result of an accidental injury
- Confinements in hospitals owned or operated by the national government, unless a charge is made, whether or not there is insurance coverage
- Injury or sickness covered by Workers' Compensation or any occupational disease law.

Also excluded:

- Outpatient procedures
- Confinement in a clinic, facility or unit of a hospital that provides custodial care, educational care, nursing care, aged care, care for drug addicts or alcoholics or rehabilitation
- Confinement in a military or veterans hospital, contracted for, or operated by, a national government or its agency unless the services are rendered on an emergency basis and in the absence of insurance, a legal liability exists to pay the charges for services given.

What insurance company makes this plan available to me?

Life Insurance Company of North America (LINA), underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates LINA "A, Excellent."

This plan provides HOSPITAL INDEMNITY insurance only. This information is a brief description of important features of the plan. It is not a contract. Terms and conditions of coverage are set forth on Policy Form No. 604852 (FL), issued in Florida. The group policy is subject to the laws of the state in which it is issued.

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Cigna® Hospital Indemnity Plan Coverage

Coverage at $50.00 Per Day	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
Employee	$2.55	$2.13	$1.96
Employee + Family	$3.30	$2.75	$2.54
Family Only	$0.75	$0.63	$0.58
Coverage at $100.00 Per Day	**10-month (20 Deductions)**	**11-month (24 Deductions)**	**12-month (26 Deductions)**
Employee	$5.10	$4.25	$3.92
Employee + Family	$6.60	$5.50	$5.08
Family Only	$1.50	$1.25	$1.15
Coverage at $150.00 Per Day	**10-month (20 Deductions)**	**11-month (24 Deductions)**	**12-month (26 Deductions)**
Employee	$7.65	$6.38	$5.88
Employee + Family	$9.90	$8.25	$7.62
Family Only	$2.25	$1.88	$1.73

MetLife Voluntary Life Insurance

You may purchase $10,000 to $100,000 (in $10,000 increments) of group term life insurance. This insurance supplements your Board-provided life insurance. You can have up to $50,000 in tax-free life insurance.

Under Section 79 of the IRS Code, employees are liable to pay federal income taxes on Group Term Life insurance amounts in excess of $50,000, to the extent that the costs for amounts in excess of $50,000, less any employee contributions for the entire coverage amount, is included in the employee's gross income. This additional amount will be listed as imputed income on your W-2.

Who is eligible?

All full-time employees are eligible; however, if you are totally disabled or not in active service for other reasons, your effective date of insurance or change in coverage will be delayed until the date of your return to Active Service.

How do I obtain claim forms?

To obtain claim forms, call the MetLife onsite representative at 305.995.7029.

Are the premiums taxable?

Under current Internal Revenue Code rules and regulations, employees whose life insurance is more than $50,000 will have premiums for any amount more than $50,000 included as taxable income on their W-2 forms. Please refer all tax-related questions to your tax advisor.

How much does the plan cost?

EMPLOYEE ONLY	10-MONTH (20 Deductions)	11-MONTH (24 Deductions)	12-MONTH (26 Deductions)
$10,000	$1.80	$1.50	$1.38
$20,000	$3.60	$3.00	$2.77
$30,000	$5.40	$4.50	$4.15
$40,000	$7.20	$6.00	$5.54
$50,000	$9.00	$7.50	$6.92
$60,000	$10.80	$9.00	$8.31
$70,000	$12.60	$10.50	$9.69
$80,000	$14.40	$12.00	$11.08
$90,000	$16.20	$13.50	$12.46
$100,000	$18.00	$15.00	$13.85

* Disability is defined as the inability to perform all the essential duties of any occupation for which you may reasonably become qualified based on training, education or experience.

Must I still pay my premiums if I'm disabled and unable to work?

If you become totally disabled prior to age 60 and that disability lasts for nine consecutive months, during which time premiums are paid, the insurance company will continue your life insurance in force without further payment of premiums if proof of such disability is provided and waiver is approved.

Is there any situation that would exclude my benefits?

If you commit suicide while you are sane or insane within two years of the effective date of coverage, benefits will not be paid; however, your beneficiary will receive a refund of the premiums you have paid for this insurance.

Also, if coverage was elected while you were on a leave of absence due to a disability and you did not return to work, benefits will not be paid. However, your beneficiary will receive a refund of the premiums you have paid for this insurance.

Does the plan pay any benefits if I am terminally ill ?

The plan will pay a lump sum—50 percent of the life insurance benefit amount in force to a maximum of $50,000 if you are terminally ill and your life expectancy is six months or less. Your benefits paid to you will reduce the death benefit. This benefit is payable only once in your lifetime.

Is there any situation that would reduce my benefit amount?

All benefits are subject to reduction after age 64 as follows:

- At age 65, to 65 percent of the original face value of coverage in force
- At age 70, to 45 percent of the original face value of coverage amount in force
- At age 75, to 30 percent of the original face value of coverage amount in force
- At age 80, to 20 percent of the original face value of coverage amount in force

Can I convert my Employee-Paid life insurance if I terminate employment?

Yes. You may apply for a conversion policy for all or any portion of life insurance in effect at termination, if you make a request. You must complete a conversion application within 31 days of termination. To request a conversion application, contact the MetLife onsite representative at 305.995.7029.

MetLife Voluntary Life Insurance

Can I continue my Employee-Paid life insurance if I retire?

Yes. Upon retirement, employees may continue their coverage at their current level of coverage subject to the maximum of their class. You may not add or increase your existing coverage. If at any time of your retirement you do NOT elect to continue this coverage, you will no longer be eligible for coverage under this plan and your group life coverage will be terminated. The maximum for actives is $100,000. The maximum for retirees is $100,000.

Additional Features:

If you participate in MetLife's Optional Life Insurance, you will receive the following additional plan features:

- Will Preparation. This feature is offered by Hyatt Legal Plans, a MetLife company that will provide you access to a participating plan attorney to help you prepare or update your or your spouse's will at no cost if you choose to use an attorney that participates in the network.
- Estate Resolution Services. This is offered by Hyatt Legal Plans, Inc., a MetLife company and provides probate services to beneficiaries who are executors or administrators of the deceased employee's estate at no additional cost. These services include telephone and office consultations to discuss matters of probate, document preparation and representation at court proceedings needed to transfer the probate assets and the completion of correspondence necessary to transfer non-probate assets.

What insurance company makes this plan available to me?

Metropolitan Life Insurance Company. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates MetLife "A+, Superior."

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

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

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life insurance coverage are set forth in Group Policy No 24400, issued in Florida. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D), provides benefits for you or your insured dependents in the event of a covered accident—on or off the job—which results in loss of life, limbs, use of limbs, eyesight, hearing or speech. You may select $25,000 to $500,000 (in $25,000 increments) of coverage.

You must be enrolled for coverage in order to cover your dependents. Your dependent's coverage is a percentage of your selected benefit amount. They are as follows:

Spouse - The spouse's benefit amount will be 40 percent of the employee's, or 50 percent if the employee has no dependent children. This amount cannot exceed $250,000.

Children - Each covered child's benefit amount will be 10 percent of the employee's, or 15 percent if the employee has no spouse. The maximum children's benefit is $25,000.

What accidents are not covered?

Benefits will not be paid for a loss caused by or resulting from:

- Sickness, physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound;
- Suicide or attempted suicide; intentionally self-inflicted injury;
- Service in the armed forces of any country or international authority, except the United States National Guard;
  Any incident related to:
  1) travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  2) travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  3) parachuting or otherwise exiting from an aircraft while such aircraft is in flight except for self preservation;
  4) travel in an aircraft or device used for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
  1) any drug, medication or sedative, unless it is: taken or used as prescribed by a Physician, or an "over the counter" drug, medication or sedative, taken as directed;
  2) alcohol in combination with any drug, medication, or sedative; or
  3) poison, gas, or fumes; or war, whether declared or undeclared; or any act of war, insurrection, rebellion, or riot; or driving a vehicle or other device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or other device was being operated.

Employees under the AFSCME bargaining units are not eligible to purchase this product.

Who is eligible?

An employee will become insured on the date the employee becomes eligible.

All full-time employees who are employed and compensated for services by the employer in accordance with the employer's general practices and work a minimum of 17 hours per week.

What injuries are covered and for how much?

Accidental Death and Dismemberment (AD&D) will pay the following percentage of the amount of coverage you purchase (from $25,000 up to $500,000 for employee coverage) if, within 365 days of an eligible accident, bodily injuries result in:

• Loss of life	100%
• Total paralysis of arms and legs	100%
• Loss of any combination of two: hands, feet or eyesight	100%
• Loss of speech and hearing in both ears	100%
• Loss of arm/leg permanently severed at or above elbow/knee	75%
• Total paralysis of both legs	50%
• Total paralysis of arm and leg on one side of the body	50%
• Loss of one hand, foot or sight in one eye	50%
• Loss of speech or hearing in both ears	50%
• Loss of thumb and index finger on the same hand	25%

For example, if you purchase $200,000 in coverage for yourself and you are in an accident that results in your death, the benefit would pay $200,000.

If the accident results in total paralysis of both your legs, the benefit would pay $100,000. If the accident results in loss of your thumb and index finger on the same hand, the benefit would pay $50,000.

If you or a dependent sustain more than one covered loss due to an accidental injury, the amount we will pay will not exceed the full amount

Accidental Death and Dismemberment (AD&D)

Benefits will be reduced based upon the age of you or your spouse:

- If you are age 70 to 74, benefits will be reduced to 75 percent of the amount of coverage.
- If you are age 75 to 79, benefits will be reduced to 45 percent of the amount of coverage.
- If you are age 80 to 84, benefits will be reduced to 30 percent of the amount of coverage.
- If you are age 85 and over, benefits will be reduced to 15 percent of the amount of coverage.
- Coverage for children ends when they no longer qualify as eligible dependents.

Can I purchase coverage for my dependents?

If you sign up for employee coverage under the Employee-Paid FlexPlan Benefit you can also choose to select coverage for your family. The amount of insurance applies to only those dependents insured at the time the loss occurs. Benefits are as follows:

- Spouse-only coverage will provide 50 percent of the employee's coverage to a maximum of $250,000
- Children-only coverage will provide 15 percent of the employee's coverage, with a maximum of $25,000 per child.
- Spouse and children coverage will provide 40 percent of the employee's coverage for the spouse and 10 percent of the employee's coverage for each dependent child, with a maximum of $25,000 per child.

How do I obtain claim forms?

To obtain claim forms, call the MetLife's onsite representative at 305.995.7029. **NOTE:** Dependent Eligibility will be determined at the time of claim.

Can I port my Employee-Paid insurance when I terminate employment?

MetLife will reach out to you via mail to advise you of your right to port this policy.

What insurance company makes this plan available to me?

Metropolitan Life Insurance Company. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates MetLife "A+, Superior."

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life insurance coverage are set forth in Group Policy # OK 82 11 33 on Policy form # LM-2160, issued in Florida. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

Are benefits taxable?

The IRS may require you to pay taxes on payments you receive from the AD&D Coverage plan under current law. For further information, consult your personal tax advisor.

Accidental Death and Dismemberment (AD&D)

What other benefits does this policy offer?

BENEFIT	WHEN IT APPLIES	AMOUNT
Seatbelt	Upon death from injuries sustained in an accident while driving or riding as a passenger in a passenger car*, provided the person was wearing a properly fastened seat belt that meets published, US Government safety standards, is properly installed by the manufacturer and has not been altered after installation, at the time of the accident. * Passenger car is any validly registered four-wheel private passenger car. It does not include any commercially licensed car or a private car that is being sued for commercial purposes, recreation or professional racing.	An additional 10 percent of the benefit amount up to $25,000; minimum amount is $1,000. The correct position of the seat belt must be certified by the investigating officer or included in the official accident report and a copy of the police report must be submitted with a claim for this benefit.
Education*	The Child Education Benefit provides an additional benefit equal to the tuition charges for each eligible dependent child to attend college or another accredited institution for up to 4 consecutive years as long as the child is: enrolled in an accredited college, university or vocational school above the 12th grade level at the time of the employee's accidental death; or is at the 12th grade level and, within one year after the employee's accidental death, enrolls as a full-time student in an accredited college, university or vocational school.	The benefit amount will not exceed $5,000 per year and an overall maximum of 2% of the employee's AD&D Full Amount. If at the time of the accident there are no dependents who qualify for the education benefit, the plan will pay an additional benefit of $1,000 to the designated beneficiary.
Spouse Training	If your spouse is enrolled in an accredited school on the date of your death or enrolls in such a school within 12 months of the date of your death.	The additional amount we will pay is equal to the tuition charges for 1 academic year up to $5,000 per year. The overall maximum additional benefit is 2% of the AD&D Full Amount. If there is no Spouse who qualifies, $1,000 will be paid to the beneficiary.
Cobra Continuation	If benefit is paid for a covered loss of your life.	Up to $4,500 reimbursement per year for three (3) years. Minimum amount is $1,000 and maximum amount is 3% of the full amount.
Hospital Confinement Daily Income Benefit	This benefit becomes payable if a covered person is confined in a hospital as a result of an accidental injury.	Pays an additional monthly benefit equal to 1% of the AD&D Full Amount the lesser of or $2,500. Benefits will be determined on a pro-rate basis for partial month of confinement. If more than one confinement for any one accident, we will pay for just one hospital confinement. We will pay for the first confinement while under doctor's care.
Child day care benefit	The Child Care Benefit provides an additional amount equal to the Child Care Center* for each eligible dependent child, 11 years of age or younger, to attend a licensed Child Care Center for up to 4 consecutive years as long as the eligible child is enrolled in a Child Care Center at the time of the employee's accidental death.	Additional amount equal to the Child Care Center* charge up to a maximum of $7,500 per year and an overall maximum of 3% of the AD&D Full Amount. * Child Care Center means a facility that is operated and licensed according to the law of the jurisdiction where it is located and provides care and supervision for children in a group setting on a regularly scheduled and daily basis. This benefit is paid quarterly when MetLife receives proof that Child Care Center charges have been paid. Payment is made to the person who pays the charges on behalf of the Child.

* If, at the time of the accident, you have coverage for your family but there is no dependent who is or could become eligible for the education or spouse education benefits, an additional benefit of $1,000 will be paid to the insured's designated beneficiary.

* If, at the time of the accident, you have coverage for your family but there is no dependent who is or could become eligible for the education or spouse education benefits, an additional benefit of $1,000 will be paid to the insured's designated beneficiary.

Accidental Death and Dismemberment (AD&D)

BENEFIT	WHEN IT APPLIES	AMOUNT
WAIVER OF PREMIUM PROVISION	The Waiver of Premium disability provision applies to total disabilities beginning before age 60. Proof that the you have been continuously, totally, disabled for at least 9 months must be provided to MetLife within 12 months of the date your total disability begins. During the waiting period, premium payment is continued through the employer and is not refundable. Waiver of Premium begins once MetLife determines proof of total disability to be satisfactory. Employees who become totally disabled on or after the effective date of coverage and: • the coverage is still in effect; • the coverage is still in effect; • the disability occurred before the employee attained age 60; and • the application for total disability is approved; Will have continuing coverage without premium payment until death. Continuation will end at the earliest of: • the date of your death • the date you are no longer • totally disabled, • the date you attain age 65, • the date you have not given us proof of total disability, and • the date you refuse to be examined by our physician At age 65, If you remain on disability, the death benefit will reduce to zero.	

Accidental Death and Dismemberment (AD&D)

Value-Added Features:

Air Bag Benefit:
If an Air Bag is deployed for the covered person during the accident and the covered person dies as a result of the accident while driving or riding in a passenger car* and wearing a properly fastened seat belt, we will pay an additional benefit of 5% of the AD&D Full Amount to a maximum of $10,000. When the Air Bag Benefit and the Seat Belt Benefit both apply, the combined additional benefit will not exceed 15% of the AD&D Full Amount, to a combined maximum of $20,000.

* Passenger Car is any validly registered four-wheel private passenger vehicle. It does not include any commercially licensed car; or a private passenger car that is being used for commercial purposes, or any vehicle used for recreational or professional racing.

Brain Damage Benefit:
Brain Damage is a covered loss that pays a benefit equal to 100% of the AD&D Full Amount as long as the brain damage* manifests itself within 30 days of the accidental injury, the covered person requires hospitalization for at least 5 days and brain damage persists for 12 consecutive months after the injury.

* Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life.

Child Care Benefit:
The Child Care Benefit provides an additional amount equal to the Child Care Center* charge up to a maximum of $7,500 per year and an overall maximum of 3% of the AD&D Full Amount for each eligible dependent child, 11 years of age or younger, to attend a licensed Child Care Center for up to 4 consecutive years as long as the eligible child is enrolled in a Child Care Center at the time of the employee's accidental death.

If no child qualifies, $1,000 will be paid to the covered person's beneficiary.

* Child Care Center means a facility that is operated and licensed according to the law of the jurisdiction where it is located and provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

This benefit is paid quarterly when MetLife receives proof that Child Care Center charges have been paid. Payment is made to the person who pays the charges on behalf of the Child.

Child Education Benefit:
The Child Education Benefit provides an additional benefit equal to the tuition charges for each eligible dependent child to attend college or another accredited institution for up to 4 consecutive years as long as the child is: enrolled in an accredited college, university or vocational school above the 12th grade level at the time of the employee's accidental death; or is at the 12th grade level and, within one year after the employee's accidental death, enrolls as a full-time student in an accredited college, university or vocational school. The benefit amount will not exceed $5,000 per year and an overall maximum of 2% of the employee's AD&D Full Amount.

If at the time of the accident there are no dependents who qualify for the education benefit, the plan will pay an additional benefit of $1,000 to the designated beneficiary.

Coma Benefit:
Coma is a covered loss that provides a benefit amount of 1% monthly of the AD&D Full Amount up to a maximum of 60 months if a covered person goes into a coma* as a result of an accidental injury and independent of other causes. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

* Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused.

Common Carrier Benefit:
The Common Carrier Benefit pays an additional benefit in an amount equal to 100% of the AD&D Full Amount if a covered person dies as a result of an accidental injury while traveling in a Common Carrier*.

* Common Carrier means a government regulated entity that is in the business of transporting fare-paying passenger. This does not include chartered or other privately arranged transportation, taxis, or limousines.

Common Disaster Benefit for VADD:
If the employee and the employee's spouse are injured in the same accident and die as a result of injuries sustained in the accident, the spouse's benefit amount will be increased to 100% of the VAD&D Full Amount payable for the employee's loss of life.* In Texas, Children age 25 only and Student age 25 only.

Exposure:
MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Full Amount:
Regarding Accidental Death & Dismemberment, the scheduled dollar benefit amount for an accidental death and certain accidental injuries.

Hospitalized:
Includes inpatient hospital care, care in a hospice, intermediate or long-term care facility, or receipt of chemotherapy, radiation therapy, or dialysis treatment wherever performed.

Hospital Confinement Benefit:
Hospital Confinement Benefit pays an additional monthly benefit equal to 1/30th of 1% of the AD&D Full Amount if a covered person is confined in a Hospital as a result of an accidental injury. Benefits begin on the ~~5~~ 4th day of continuous confinement and are subject to a monthly limit of $2,500 and a maximum duration of 12 continuous months.

Benefits will be determined on a pro-rate basis for partial month of confinement. If more than one confinement for any one accident, we will pay for just one hospital confinement. We will pay for the first confinement.

* Hospital means a facility which is licensed as such in the jurisdiction in which it is located and; provides a broad range of medical and surgical services on a 24 hour a day basis for injured and sick persons by or under the supervision of staff of Physicians; and provides a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.

Accidental Death and Dismemberment (AD&D)

Travel Assistance & Identity Theft Solutions:
Employees and their dependents enrolled in MetLife's Accidental Death & Dismemberment coverage will have access to Travel Assistance services that provide immediate access to doctors, hospitals, pharmacies, and certain other services when faced with an emergency while traveling internationally or domestically more than 100 miles from home.

Covered employees and their dependents may travel (together or separately) with greater peace of mind knowing that they are just one phone call away from being connected to a global alarm center to provide vital assistance services including: Medical Consultation and Evaluation, Emergency Evacuation, Dispatch of Prescription Medication, and even Emergency Message Transmission.

Identity Theft Solutions, an additional benefit packaged with Travel Assistance, educates participants on preventing identify theft and provides personal assistance and guidance to help alleviate the stress and time burden that victims of identity theft often face. This important feature can be used while the Participant is home or away and is available 24 hours a day 365 days a year. Participants receive assistance with filing police reports, contacting creditor fraud departments, taking inventory of lost or stolen items and more.

There is no travel requirement and no additional charge for Identity Theft Solutions.

Travel Assistance services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by ACE American Insurance Company. AXA Assistance and ACE American are not affiliated with MetLife, and the Travel Assistance & Identity Theft Solutions services they provide are separate and apart from the insurance provided by MetLife.

Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

Presumption of Death:
A person will be presumed to have died as a result of an accidental injury if the aircraft or other vehicle in which the person is traveling disappears, sinks or is wrecked and the person's body is not found within 1 year of the date the aircraft or vehicle was scheduled to have arrived at its destination, or, if not a Common Carrier, the date the person was reported missing to authorities.

Seat Belt Benefit:
Seat Belt Benefit provides an additional benefit equal to 10% of the AD&D Full Amount , subject to a minimum benefit of $1,000, up to a maximum of $25,000 if a covered person dies from injuries sustained in an accident while driving or riding as a passenger in a Passenger Car*, provided the person was wearing a properly fastened Seat Belt* at the time of the accident. When the Seat Belt Benefit and the Air Bag Benefit both apply, the combined additional benefit will not exceed 15%.

* Passenger Car: Any validly registered four-wheel private passenger car. It does not include any commercially licensed car; or a private car that is being used for commercial purposes, or any vehicle used for recreation or professional racing.

* Seat Belt means any restraint device that meets published, US Government safety standards, is properly installed by the car manufacturer and has not been altered after installation. The term also includes a child restraint device that meets the requirements of state law.

The correct position of the seat belt must be certified by the investigating officer or included in the official accident report, and a copy of the police report must be submitted with a claim for this benefit..

Spouse Education Benefit:
If the Spouse is enrolled in an accredited school on the date the covered employee dies, or enrolls in such a school within 12 months of the employee's death, the additional amount we will pay is equal to the tuition charges for 1 academic year up to $5,000 per year and an overall maximum of 2% of the employee's AD&D Full Amount.

If there is no Spouse who qualifies, $1,000 will be paid to the beneficiary.

What insurance company makes this plan available to me?

Metropolitan Life Insurance Company, underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates MetLife "A+ Superior"

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life insurance coverage are set forth in Group Policy # 24400, issued in Florida. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is a summary of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance company.

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

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D)

Employee Coverage

	10-MONTH (20 Deductions)			11-MONTH (24 Deductions)			12-MONTH (26 Deductions)		
	EE Only	EE & Family	Family Only	EE Only	EE & Family	Family Only	EE Only	EE & Family	Family Only
$25,000	$0.20	$0.39	$0.20	$0.16	$0.33	$0.16	$0.15	$0.30	$0.15
$50,000	$0.39	$0.78	$0.39	$0.33	$0.65	$0.33	$0.30	$0.60	$0.30
$75,000	$0.59	$1.17	$0.59	$0.49	$0.98	$0.49	$0.45	$0.90	$0.45
$100,000	$0.78	$1.56	$0.78	$0.65	$1.30	$0.65	$0.60	$1.20	$0.60
$125,000	$0.98	$1.95	$0.98	$0.81	$1.63	$0.81	$0.75	$1.50	$0.75
$150,000	$1.17	$2.34	$1.17	$0.98	$1.95	$0.98	$0.90	$1.80	$0.90
$175,000	$1.37	$2.73	$1.37	$1.14	$2.28	$1.14	$1.05	$2.10	$1.05
$200,000	$1.56	$3.12	$1.56	$1.30	$2.60	$1.30	$1.20	$2.40	$1.20
$225,000	$1.76	$3.51	$1.76	$1.46	$2.93	$1.46	$1.35	$2.70	$1.35
$250,000	$1.95	$3.90	$1.95	$1.63	$3.25	$1.63	$1.50	$3.00	$1.50
$275,000	$2.15	$4.29	$2.15	$1.79	$3.58	$1.79	$1.65	$3.30	$1.65
$300,000	$2.34	$4.68	$2.34	$1.95	$3.90	$1.95	$1.80	$3.60	$1.80
$325,000	$2.54	$5.07	$2.54	$2.11	$4.23	$2.11	$1.95	$3.90	$1.95
$350,000	$2.73	$5.46	$2.73	$2.28	$4.55	$2.28	$2.10	$4.20	$2.10
$375,000	$2.93	$5.85	$2.93	$2.44	$4.88	$2.44	$2.25	$4.50	$2.25
$400,000	$3.12	$6.24	$3.12	$2.60	$5.20	$2.60	$2.40	$4.80	$2.40
$425,000	$3.32	$6.63	$3.32	$2.76	$5.53	$2.76	$2.55	$5.10	$2.55
$450,000	$3.51	$7.02	$3.51	$2.93	$5.85	$2.93	$2.70	$5.40	$2.70
$475,000	$3.71	$7.41	$3.71	$3.09	$6.18	$3.09	$2.85	$5.70	$2.85
$500,000	$3.90	$7.80	$3.90	$3.25	$6.50	$3.25	$3.00	$6.00	$3.00

Benefit payout will be:

Spouse only coverage = 50 percent of employee's coverage

Children only coverage = 15 percent of employee coverage

Spouse & Children = Spouse 40 percent of employee's coverage

Each child 10 percent of employee's coverage

Beyond Your Benefits

FBMC Privacy Notice 4/14/03

As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of Service Center and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

We maintain safeguards to ensure information security and are committed to preventing unauthorized access to personal information.

We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA). You may receive a Privacy Notice from your employer or from the providers of various health plans in which you enroll. You should read these statements carefully to assure you understand your rights under HIPAA.

Notice of Administrator's Capacity

PLEASE READ: This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder, and the insurer:

1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

Taxable Benefits and the IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pre-tax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual medical expenses you incur, if these premiums were paid with pre-tax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than:

- 48 hours following a vaginal delivery; OR
- 96 hours following a cesarean section

Determination of when the hospital stay begins is based on the following:

- For an in the hospital delivery:
- The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center):
- The stay begins at the time of admission to the hospital.
- Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.
- These rules do not mandate hospital stay benefits on a plan that does not provide that coverage.
- The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

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, 2012 for an effective date of January 1, 2013.
- 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 2012, through December 2012.

For more information refer to your "Medicare & You 2013" 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

Enrollment in Medicare While Actively Working

Active Employees Eligible for Medicare Parts A & B:

- If you and/or your covered dependent are eligible for Medicare Parts A & B, you are provided the opportunity of enrolling in Medicare during the Special Enrollment Period.
- You do not need to enroll in Medicare while working and covered by a group healthcare plan through your employer. Please refer to your 2013 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 enrol in heathcare, call the FBMC Service Center at 1.855.5MYFBMC (1.855.569.3262).

Rates at-a-Glance

Medical Premiums - Employee Cost Share, Effective 1/1/2013

Full Time - Salary <= $25k		10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Cigna - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse/Domestic Partner	$87.00	$72.50	$66.92
	Children	$62.40	$52.00	$48.00
	Family	$166.20	$138.50	$127.85
	Employee & Domestic Partner with Children	$166.20	$138.50	$127.85
	Employee with Children & Domestic Partner	$166.20	$138.50	$127.85
Cigna - OAP10	Employee	*$55.20	*$46.00	*$42.46
	Spouse	$94.80	$79.00	$72.92
	Children	$66.00	$55.00	$50.77
	Family	$188.40	$157.00	$144.92
	Employee & Domestic Partner with Children	$188.40	$157.00	$144.92
	Employee with Children & Domestic Partner	$188.40	$157.00	$144.92

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

Full Time - Salary >25k - 40k		10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Cigna - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse/Domestic Partner	$129.60	$108.00	$99.69
	Children	$97.80	$81.50	$75.23
	Family	$235.20	$196.00	$180.92
	Employee & Domestic Partner with Children	$235.20	$196.00	$180.92
	Employee with Children & Domestic Partner	$235.20	$196.00	$180.92
Cigna - OAP10	Employee	*$73.20	*$61.00	*$56.31
	Spouse/Domestic Partner	$126.00	$105.00	$96.92
	Children	$87.60	$73.00	$67.38
	Family	$250.80	$209.00	$192.92
	Employee & Domestic Partner with Children	$250.80	$209.00	$192.92
	Employee with Children & Domestic Partner	$250.80	$209.00	$192.92

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

Full Time - Salary > 40k - 55k		10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Cigna - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse/Domestic Partner	$203.40	$169.50	$156.46
	Children	$159.00	$132.50	$122.31
	Family	$332.40	$277.00	$255.69
	Employee & Domestic Partner with Children	$332.40	$277.00	$255.69
	Employee with Children & Domestic Partner	$332.40	$277.00	$255.69
Cigna - OAP10	Employee	*$84.00	*$70.00	*$64.62
	Spouse/Domestic Partner	$199.20	$166.00	$153.23
	Children	$147.00	$122.50	$113.08
	Family	$352.80	$294.00	$271.38
	Employee & Domestic Partner with Children	$352.80	$294.00	$271.38
	Employee with Children & Domestic Partner	$352.80	$294.00	$271.38

* 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.

Rates at-a-Glance

Medical Premiums - Employee Cost Share, Effective 1/1/2013

Full Time - Salary >55k - 85k		10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Cigna - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse/Domestic Partner	$235.20	$196.00	$180.92
	Children	$184.80	$154.00	$142.15
	Family	$381.60	$318.00	$293.54
	Employee & Domestic Partner with Children	$381.60	$318.00	$293.54
	Employee with Children & Domestic Partner	$381.60	$318.00	$293.54
Cigna - OAP10	Employee	*$94.80	*$79.00	*$72.92
	Spouse/Domestic Partner	$225.00	$187.50	$173.08
	Children	$166.80	$139.00	$128.31
	Family	$398.40	$332.00	$306.46
	Employee & Domestic Partner with Children	$398.40	$332.00	$306.46
	Employee with Children & Domestic Partner	$398.40	$332.00	$306.46

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

Full Time - Salary >85k		10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Cigna - OAP20	Employee	$0.00	$0.00	$0.00
	Spouse/Domestic Partner	$267.00	$222.50	$205.38
	Children	$211.20	$176.00	$162.46
	Family	$430.20	$358.50	$330.92
	Employee & Domestic Partner with Children	$430.20	$358.50	$330.92
	Employee with Children & Domestic Partner	$430.20	$358.50	$330.92
Cigna - OAP10	Employee	*$106.20	*$88.50	*$81.69
	Spouse/Domestic Partner	$250.20	$208.50	$192.46
	Children	$184.80	$154.00	$142.15
	Family	$444.00	$370.00	$341.59
	Employee & Domestic Partner with Children	$444.00	$370.00	$341.59
	Employee with Children & Domestic Partner	$444.00	$370.00	$341.59

* 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.

Rates at-a-Glance

1/1/2013 - 12/31/2013

Disability Insurance

The Hartford Employee Coverage

Short-Term	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Standard Upgrade	$3.28	$2.74	$2.52
High	$1.21	$1.01	$0.93
High Upgrade	$5.29	$4.41	$4.07
Long-Term	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Level 1	$14.48	$12.07	$11.14
Level 2	$18.56	$15.47	$14.28
Level 3	$27.98	$23.32	$21.52

Level 4 For Level 4 coverage (available only if your salary is in excess of $100,000), determine your premium by choosing a payroll cycle and following ONE of the formulas below:

For 10-month (20 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06 ÷ 20 = $_____

For 11-month (24 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06 ÷ 24 = $_____

For 12-month (20 Deductions), use this formula: Annual Salary* $ _____ ÷ 100 x 1.06 ÷ 26 = $_____

* If your salary exceeds $150,000, enter $150,000 here.

Dental

SafeGuard DHMO Plans

	10-MONTH (20 Deductions)		11-MONTH (24 Deductions)		12-MONTH (26 Deductions)	
	High	Standard	High	Standard	High	Standard
Employee	$7.49	$5.30	$6.25	$4.42	$5.76	$4.08
Employee & Family	$19.13	$13.50	$15.94	$11.25	$14.71	$10.38

MetLife Dental Plan

Standard Indemnity	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Employee	$10.38	$8.65	$7.78
Employee & Family	$31.84	$26.54	$24.49

High Indemnity	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Employee	$21.68	$18.07	$16.68
Employee & Family	$64.83	$54.03	$49.87

Vision

UnitedHealthcare Vision Plan

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

Identity Theft

ID Watchdog Identity Theft Plan

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Employee	$4.77	$3.98	$3.67
Employee & Family	$8.97	$7.48	$6.90

Rates at-a-Glance

1/1/2013 - 12/31/2013

Hospital Indemnity Plan Coverage

Cigna® Hospital Indemnity Plan Coverage

Coverage at $50.00 Per Day	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Employee	$2.55	$2.13	$1.96
Employee + Family	$3.30	$2.75	$2.54
Family Only	$0.75	$0.63	$0.58

Coverage at $100.00 Per Day	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Employee	$5.10	$4.25	$3.92
Employee + Family	$6.60	$5.50	$5.08
Family Only	$1.50	$1.25	$1.15

Coverage at $150.00 Per Day	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
Employee	$7.65	$6.38	$5.88
Employee + Family	$9.90	$8.25	$7.62
Family Only	$2.25	$1.88	$1.73

MetLife Life Insurance

Employee-only	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
$10,000	$1.80	$1.50	$1.38
$20,000	$3.60	$3.00	$2.77
$30,000	$5.40	$4.50	$4.15
$40,000	$7.20	$6.00	$5.54
$50,000	$9.00	$7.50	$6.92
$60,000	$10.80	$9.00	$8.31
$70,000	$12.60	$10.50	$9.69
$80,000	$14.40	$12.00	$11.08
$90,000	$16.20	$13.50	$12.46
$100,000	$18.00	$15.00	$13.85

Legal Coverage

ARAG

NOTE: These premiums will be deducted on a post-tax basis.

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions) ARAG
Group Legal Plan	$10.38	$8.65	$7.98
ARAG Senior Advocate Program	$4.66	$3.88	$3.58

US Legal Plans

NOTE: These premiums will be deducted on a post-tax basis.

	10-month (20 Deductions)	11-month (24 Deductions)	12-month (26 Deductions)
US Legal Family Defender	$10.14	$8.45	$7.80
US Legal Senior Defender	$4.65	$3.88	$3.58

Rates at-a-Glance

Accidental Death and Dismemberment (AD&D), 1/1/2013 - 12/31/2013

Accidental Death and Dismemberment (AD&D)

Employee Coverage

	10-MONTH (20 Deductions)			11-MONTH (24 Deductions)			12-MONTH (26 Deductions)		
	EE Only	EE & Family	Family Only	EE Only	EE & Family	Family Only	EE Only	EE & Family	Family Only
$25,000	$0.20	$0.39	$0.20	$0.16	$0.33	$0.16	$0.15	$0.30	$0.15
$50,000	$0.39	$0.78	$0.39	$0.33	$0.65	$0.33	$0.30	$0.60	$0.30
$75,000	$0.59	$1.17	$0.59	$0.49	$0.98	$0.49	$0.45	$0.90	$0.45
$100,000	$0.78	$1.56	$0.78	$0.65	$1.30	$0.65	$0.60	$1.20	$0.60
$125,000	$0.98	$1.95	$0.98	$0.81	$1.63	$0.81	$0.75	$1.50	$0.75
$150,000	$1.17	$2.34	$1.17	$0.98	$1.95	$0.98	$0.90	$1.80	$0.90
$175,000	$1.37	$2.73	$1.37	$1.14	$2.28	$1.14	$1.05	$2.10	$1.05
$200,000	$1.56	$3.12	$1.56	$1.30	$2.60	$1.30	$1.20	$2.40	$1.20
$225,000	$1.76	$3.51	$1.76	$1.46	$2.93	$1.46	$1.35	$2.70	$1.35
$250,000	$1.95	$3.90	$1.95	$1.63	$3.25	$1.63	$1.50	$3.00	$1.50
$275,000	$2.15	$4.29	$2.15	$1.79	$3.58	$1.79	$1.65	$3.30	$1.65
$300,000	$2.34	$4.68	$2.34	$1.95	$3.90	$1.95	$1.80	$3.60	$1.80
$325,000	$2.54	$5.07	$2.54	$2.11	$4.23	$2.11	$1.95	$3.90	$1.95
$350,000	$2.73	$5.46	$2.73	$2.28	$4.55	$2.28	$2.10	$4.20	$2.10
$375,000	$2.93	$5.85	$2.93	$2.44	$4.88	$2.44	$2.25	$4.50	$2.25
$400,000	$3.12	$6.24	$3.12	$2.60	$5.20	$2.60	$2.40	$4.80	$2.40
$425,000	$3.32	$6.63	$3.32	$2.76	$5.53	$2.76	$2.55	$5.10	$2.55
$450,000	$3.51	$7.02	$3.51	$2.93	$5.85	$2.93	$2.70	$5.40	$2.70
$475,000	$3.71	$7.41	$3.71	$3.09	$6.18	$3.09	$2.85	$5.70	$2.85
$500,000	$3.90	$7.80	$3.90	$3.25	$6.50	$3.25	$3.00	$6.00	$3.00

Benefit payout will be:

Spouse only coverage = 50 percent of employee's coverage

Children only coverage = 15 percent of employee coverage

Spouse & Children = Spouse 40 percent of employee's coverage

Each child 10 percent of employee's coverage

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
FBMC Service Center 1.855.5MYFBMC (1.855.569.3262) • 1.800.955.8771 (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

FBMC/M-DCPS/0513