2023-2024 Benefit Guide

October 1, 2023 – September 30, 2024

Orange County Public Schools

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Benefits Department.

Benefits Overview

Benefit Plans Offered

- Medical (with Board Contribution)
- Dental
- Vision
- Life and Accidental Death & Dismemberment (With Board Contribution)
- Group Universal Life Insurance
- Disability
- Flexible Spending Account (FSA)

Eligibility – Employees

Full-time employees working 25 hours or more per week and part-time employees working 17.5 hours or more per week will be eligible for benefits following a waiting period of 59 days, with coverage to be effective on the first day of the following month.

Full-time employees may not be covered as a dependent on another OCPS medical plan.

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

Eligibility – Dependents

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

Employees must provide documented proof of dependency at the time of enrollment or as requested by the Insurance Benefits department. Failure to provide documented proof of dependency will result in termination of the dependent on the last day of the month, following 60 days from the date of notification.

Eligible dependents include:

1. Spouse (supported by a marriage certificate)

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

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

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

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

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

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

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

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

   The premium is equal to the single adult rate for COBRA continuation coverage. Annual verification may be required.

Coverage for an unmarried dependent child who is already enrolled in an OCPS medical plan and is not able to be self-supporting because of mental or physical handicap will not end just because the child has reached a certain age. Coverage will be extended beyond the limiting age for as long as the child is incapacitated and primarily dependent upon the Covered Employee for support and maintenance. Annual documentation is required.

NOTE: When a dependent is no longer eligible for coverage, it is the Employee's responsibility to contact the Insurance Benefits Office to verify that the correct amount of premium deduction is taken. Coverage will be effective upon approval and notification from OCPS.

*DOMESTIC PARTNER TAX IMPLICATIONS

Please note, under IRS regulations, domestic partners and the children of domestic partners do not qualify as tax dependents, as a result the premiums for any plans with a domestic partner or child(ren) of a domestic partner will be deducted post-tax and the medical premiums made by OCPS on behalf of dependents will be treated as taxable income. Examples of the impact of imputed income can be found on the Insurance Benefits intranet page at **http://insurance.ocps.net**. Employees should consult a tax advisor prior to adding coverage.

Medical Benefits

Administered by Cigna

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through OCPS.

Know Your Terms!

Copay – a flat fee you pay whenever you use a medical service, like a doctor visit.

Deductible – the dollar amount you pay before your medical insurance begins paying.

Coinsurance – the percentage of medical expenses you continue to pay after you've met your deductible and before you reach your out-of-pocket maximum.

Out-of-Pocket Maximum – the most you will pay during the plan year for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Summary of Medical Plans

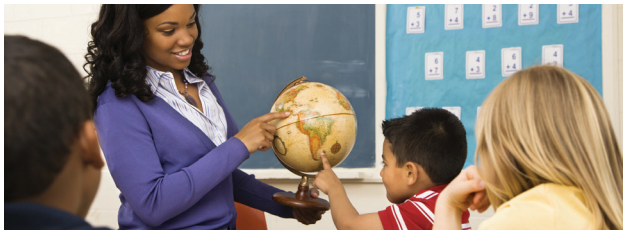
	Cigna LocalPlus (A)	Cigna Choice Fund Open Access Plus HRA (B)		Cigna Open Access Plus (C)	Cigna SureFit AdventHealth and CVS (D)
	In-Network	In-Network	Out-of-Network	In-Network	In-Network
Annual Deductible Individual / Family	$500 / $1,000	$3,000 / $6,000	$3,000 / $6,000	$400 / $800	$300 / $600
Coinsurance	20%	20%	30%	20%	10%
Medical Out-of-Pocket Maximum Individual / Family	$6,500 / $13,000	$6,500 / $13,000	$9,000 / $18,000	$6,500 / $13,000	$5,500 / $11,000
Rx Out-of-Pocket Maximum Individual / Family	$2,000 / $4,000	$2,000 / $4,000	N/A	$2,000 / $4,000	$1,500 / $3,000
PCP	$35*	$30*	30% after deductible	$30*	$35*
Virtual Care - Urgent	$10*	$10*	Not covered	$10*	$10*
Specialist	$55*	CCN**: $45* Non-CCN**: $65*	30% after deductible	$55*	$55*
Preventive Care	$0*	$0*	30% after deductible	$0*	$0*
Emergency Room	$400 copay* (copay waived if admitted)	$400 copay + 20% after deductible (copay waived if admitted)		$400 copay* (copay waived if admitted)	$400 copay* (copay waived if admitted)
Inpatient	20% after deductible	20% after deductible	30% after deductible	20% after deductible	10% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	30% after deductible	20% after deductible	10% after deductible
Urgent Care	$35*	$75*	$75*	$35*	$35*

	Cigna LocalPlus (A)	Cigna Choice Fund Open Access Plus HRA (B)		Cigna Open Access Plus (C)	Cigna SureFit AdventHealth and CVS (D)
	In-Network	In-Network	Out-of-Network	In-Network	In-Network
Diagnostic Lab and X-Ray	$0* (PCP or independent lab)	PCP: $30 copay CCN** Specialist: $45 Non-CCN** Specialist: $65 All Other: 20% coinsurance	30% after deductible	$0* (PCP or independent lab)	10% after deductible $0* (PCP)
Advanced Imaging Hospital Based	$100 copay + 20% coinsurance after deductible	$100 copay + 20% coinsurance after deductible	30% after deductible	$100 copay + 20% coinsurance after deductible	$100 copay + 10% coinsurance after deductible
Advanced Imaging Free-Standing	$100*	$100 + 20%*	30% after deductible	$100*	$100*
Mental / Behavioral Health / Substance Use Disorder Outpatient Services	Visits 1-5: No charge Visits 6-10: $10 copay/visit* Visits 11+: $20 copay/visit*	Visits 1-5: No charge Visits 6-10: $10 copay/visit* Visits 11+: $20 copay/visit*	30% after deductible	Visits 1-5: No charge Visits 6-10: $10 copay/visit* Visits 11+: $20 copay/visit*	Visits 1-5: No charge Visits 6-10: $10 copay/visit* Visits 11+: $20 copay/visit*
Mental / Behavioral Health / Substance Use Disorder Inpatient Services	10% after deductible	10% after deductible	30% after deductible	10% after deductible	10% after deductible
RX COPAYS/COINSURANCE - RETAIL 30 DAYS (MORE RX DETAILS ON PAGE 8)					
Generic	$9	$9	30% + the difference between out-of-network and the network cost to the plan	$9	$9
Brand Name Preferred	10%, minimum of $60	10%, minimum of $60		10%, minimum of $60	$60 copay
Brand Name Non Preferred	N/A***	N/A***	N/A***	N/A***	N/A***
Specialty (Medications more than $1,500 for a 30-day supply.)	10%, minimum of $100	10%, minimum of $100	30% + the difference between out-of-network and the network cost to the plan	10%, minimum of $100	$100

*You do not need to meet your deductible for this copay to apply.
**The Cigna Care Network (CCN) designates Health Care Professionals (HCP) that meet Cigna's certain criteria for quality and cost-efficiency measures.

***If a drug is not listed in the formulary, it is not covered under the plan. Certain brand-name non-formulary drugs may be provided at a participating network pharmacy if medical necessity has been determined by a CVS Caremark clinical therapeutic committee. The member's physician must provide documented usage and failure or an adverse reaction of generic and/or brand-name in formulary medications in order to verify medical necessity. Members in the Local Plus (A), HRA (B) and Open Access Plus (C) plans will pay a 10% coinsurance, minimum $90 copay for a 30-day supply, minimum $180 for a 90-day supply at CVS Retail or mail or minimum $270 for a 90-day supply at retail. Members in the SureFit (D) plan will pay a $90 copay for a 30-day supply or $180 for a 90-day supply at CVS Retail or mail.

Deductible amounts met in July, August, September apply to current plan year and following plan year.



Local Plus – Plan (A)

If you elect Plan (A), you will have access to Cigna's Local Plus Network. If you see a provider who is not in the Local Plus Network, your plan does not cover those services, except in emergencies.

To access an online provider directory for this plan, visit **www.cigna.com**, choose ***Find a Doctor***. In the How are you Covered section, select ***Employer or School***, enter a search location, select one of the following: ***Doctor by Type***, ***Doctor by Name or Health Facilities***. Choose ***Continue as guest,*** click ***Continue***, then choose ***LocalPlus***.

HRA – Plan (B)

If you were enrolled in the HRA (B) plan prior to the 2023-24 plan year, you may have funds remaining in your health reimbursement account that you can continue to use to pay for eligible out-of-pocket expenses during the Plan Year.

Out-of-Network Coverage

Plan B is the only plan offered that includes Out-of-Network coverage. However, please be aware that you will be responsible for charges in addition to the out-of-network deductible and coinsurance. Out-of-network providers will typically charge you the difference between the amounts they bill and what the carrier pays (known as balance billing). These charges are in addition to, and do not count towards your out-of-network out-of-pocket maximum.

If you elect Plan (B), you will have access to Cigna's Open Access Plus Network.

To access an online provider directory for this plan, visit **www.cigna.com**, choose ***Find a Doctor***. In the How are you Covered section, select ***Employer or School***, enter a search location, select one of the following: ***Doctor by Type***, ***Doctor by Name or Health Facilities***. Choose ***Continue as guest***, click ***Continue***, then choose ***Open Access Plus***, ***OA Plus***, ***Choice Fund OA Plus***.

This is also where you can find if your provider is included in the CCN.

OAPIN – Plan (C)

If you elect Plan (C), you will have access to Cigna's Open Access Plus Network. If you see a provider who is not in the Open Access Plus Network, your plan does not cover those services, except in emergencies.

To access an online provider directory for this plan, visit **www.cigna.com**, choose ***Find a Doctor***. In the How are you Covered section, select ***Employer or School***, enter a search location, select one of the following: ***Doctor by Type***, ***Doctor by Name*** or ***Health Facilities***. Choose ***Continue as guest***, click ***Continue***, then choose ***Open Access Plus***, ***OA Plus***, ***Choice Fund OA Plus***.

SureFit – Plan (D)

If you elect Plan (D), you will have access to Cigna's SureFit Network. If you see a provider who is not in the SureFit Network, your plan does not cover those services, except in emergencies.

To access an online provider directory for this plan, visit **www.cigna.com**, choose ***Find a Doctor***. In the How are you Covered section, select ***Employer or School***, enter a search location, select one of the following: ***Doctor by Type***, ***Doctor by Name*** or ***Health Facilities***. Choose ***Continue as guest***, click ***Continue***, then choose ***Cigna SureFit with AdventHealth Orlando***.

Pharmacy

Administered by CVS/Caremark

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

Purchasing Non-Maintenance Medications

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

Purchasing Maintenance Medications

If you or a covered family member receives a prescription for a maintenance medication (any long-term medications you are taking for 90 days or more such as cholesterol, blood pressure, diabetes, as well as oral contraceptives), you can obtain the first 30-day fill and up to two (2) 30-day refills at any participating retail pharmacy. Thereafter, you must purchase your maintenance medication through either the CVS Caremark pharmacy or the 90-day retail program at participating retail pharmacies. **Otherwise, you will be responsible for 100% of the CVS Caremark discounted cost of the medication for each subsequent fill of a 30-day supply.**

CVS Caremark Mail Service or CVS Pharmacy (Maintenance Drugs)

CVS Caremark Mail Service or CVS Pharmacy (including locations within Target) provide a 90-day supply for twice the monthly copayment or coinsurance minimum.

Retail 90 (Maintenance Drugs)

Copayments at Retail 90 are three times the 30-day copayment or 10% coinsurance. To use Retail 90 simply bring your 90-day prescription for a maintenance medication to a selected participating pharmacy. Members enrolled in SureFit (D) do not have access to Retail 90 outside of CVS Caremark Mail and CVS Retail Pharmacies.

In-Network Pharmacies

You can use major retail chains like CVS, Publix, Winn Dixie and Wal-Mart, as well as many independent pharmacies. To find a participating pharmacy, visit **www.caremark.com**, download the mobile app or call, CVS Caremark Customer Care at **800.378.9264**.

SureFit (D) plan members have access to the CVS Only Network if within 10 miles of a CVS Retail store. For those residing more than 10 miles away from a CVS Retail store, independent pharmacies will be identified for use.

Generic Drugs

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

Benefit Advocate Center

Administered by Gallagher Benefit Services

Prescription Assistance

The Benefit Advocate Center is available to assist employees and family members covered by an OCPS medical plan with pharmacy questions. Maximize your pharmacy benefit with a team of licensed healthcare advocates available Monday – Friday, 8 a.m. – 6 p.m. The Benefits Advocate Center can help you:

- Find a covered medication and the cost.
- Find an in-network pharmacy.
- Explain coverage information.

How to Contact the Benefit Advocate Center

Phone: **833.416.5130**
Email: **bac.ocps@ajg.com**

CVS Caremark provides pharmacy benefits for the OCPS plans. The Benefit Advocate Center does not replace CVS Caremark, it is an additional service available to assist members with elevated pharmacy issues.

Alternative to Medical Insurance

If you are an eligible employee but have other group medical coverage (ex: your spouse's or domestic partner's medical plan) or a Qualified Health Plan (QHP) through the Marketplace, OCPS offers an alternative. You may select this option through Employee Self Service.

This is an OCPS-paid benefit and replaces the medical benefits previously described. There is no cost to employees who opt for this benefit, full-time or part-time. Please note that waiving the OCPS offered medical coverage for a QHP may impact your subsidy through the Marketplace.

Disability and Vision Plan

DISABILITY BENEFIT	Available for employees, not dependents
Monthly Benefit	Maximum $1,500 (Not to exceed 66 2/3% of your annual base salary)
Elimination Period (Waiting Period)	14 days
Benefits are payable under Lincoln Financial Group and outlined in this guide.	
VISION BENEFIT	Available for employees and dependents
Benefits are payable under HumanaVision and outlined in this guide.	

Acceptance/Waiver of Medical Insurance for Part-Time Employees

OCPS pays a portion of the rate of the Employee-only medical insurance for part-time benefited employees working between 17.5 and 24.9 hours per week. These part-time employees have the option of paying the remaining portion of the cost for their own medical insurance, or declining coverage. If part-time employees decline coverage and later become full-time, they can accept the OCPS medical insurance at that time. It is the employee's responsibility to contact Insurance Benefits if their status changes from part-time to full-time.

Employee Assistance Program (EAP)

Administered by Cigna

Employee Assistance and Work/Life Support Program 24/7

A well-balanced offering to help you live a well-balanced life.

Give us a call or visit **www.myCigna.com** to locate referrals and resources for services such as:

- **Child Care**: We'll help you find a place, program or person that's right for your family.
- **Financial Services Referral:** Free 30-minute financial consultations by phone and 25% off tax preparation.
- **Identity Theft:** Get a free 60-minute expert consultation by phone for prevention or if you are victimized.
- **Legal Consulting:** Get a free 30-minute consultation with a network attorney and 25% off select fees.
- **Pet Care:** From vets to dog walkers, we'll help you ensure your pets are well taken care of.
- **Senior Care:** Learn about solutions related to caring for an aging loved one.

Take advantage of the convenience of consultation by phone:

- Confidential
- No cost to you or anyone living in your household
- Work with a licensed EAP clinician
- 20 to 30 minutes in length
- Unlimited number of consultations each year

Managing Stress

There are ways to manage stress and build resilience that will make your life easier. Check out the online Managing Stress Toolkit for:

- Self-assessment tools
- On-demand stress reduction seminars
- Mindfulness exercises for free download
- Helpful articles and information

Contact us to get the assistance you need.

Call **877.622.4327**.
Log in to **www.myCigna.com**.
Employer ID: ocps
For initial registration.

Dental Benefits

Administered by Delta Dental

Keep your teeth healthy and your smile bright with one of the three OCPS dental plans available through Delta Dental.

	DeltaCare® USA *		Delta Dental PPO	
	Basic Plan FLM12	Comprehensive Plan FLM97	In-Network	Out-of-Network
	Employee Copayment		Delta Dental Pays	
Office Visit Copayment	$5 per visit	$5 per visit	N/A	N/A
Diagnostic oral examinations, x-rays	No cost to $5	No cost to $5	100%	80%
Preventive routine cleanings (2 per 12-month period), fluoride treatment, sealants and space maintainers	No cost to $90	No cost to $85	100%	80%
Basic Benefits fillings, basic endodontics (root canal), basic periodontics, basic restoratives, denture repairs, oral surgery (incisions, excisions, surgical removal of tooth)	No cost to $240	No cost to $300	80%	60%
Major Benefits crowns, inlays, onlays, cast restorations, bridges, dentures, major endodontics, major periodontics (gum treatment), major restoratives and major denture repairs	$15 to $355	$12 to $375	50%	40%
Orthodontic Benefits dependent children only	75% of “filed fees”	$120 to $1,850	N/A	N/A
Deductible per calendar year	$0	$0	$25 per person $75 per family	$50 per person $150 per family
Plan Year Maximum per calendar year	N/A	N/A	$1,300 per person	$1,300 per person

*DeltaCare USA plans only include in-network coverage.

To find a DeltaCare USA dentist:
Visit **deltadentalins.com/enrollees**. Under “Find a dentist,” enter your zip code, select “DeltaCare USA” as your network, and enter a dentist, practice, or keyword.

To find a Delta Dental PPO dentist:
Visit **deltadentalins.com/enrollees**. Under “Find a dentist,” enter your zip code, select “Delta Dental PPO” as your network, and enter a dentist, practice or keyword.

Vision Benefits

Administered by Humana

Regular eye examinations can determine your need for corrective eyewear and may detect general health problems in their earliest stages.

Your coverage from a Humana doctor

	In-Network (up to plan limits, less copayments)	Out-of-Network (maximum reimbursement, less copayments)
Eye Exam — once every 12 months	Paid in Full	$35
Lenses — once every 12 months		
Single Vision Lenses	Paid in Full	$25
Bifocal Lenses	Paid in Full	$40
Trifocal Lenses	Paid in Full	$60
Lenticular Lenses	Paid in Full	$100
Frames — once every 12 months	$50 wholesale allowance	$50
Contact Lenses — once every 12 months if you elect contacts instead of lenses / frames		
Medically Necessary	One pair of contacts paid in full	$210
Elective (Fitting and Lenses)	Exam + $125	Exam + $125
Additional Plan Discounts		
	✣ Members may benefit with fixed pricing for most lens options including anti-reflective and scratch-resistant coatings. ✣ Members may also be eligible to receive up to a 20% retail discount on a second pair of eyeglasses, which is available for 12 months after the covered eye exam through the participating provider who sold the initial pair of eyeglasses. ✣ After copay, standard polycarbonate available at no charge for dependents less than 19 years old.	

Elective contact lenses are available in lieu of glasses (lenses and/or frames). You are not eligible for glasses for 12 months after you receive elective contacts, and vice-versa.

You have access to more than 35,000 participating optometrist, ophthalmologists, and national retail locations, including LensCrafters®, Pearle Vision®, Sears® Optical, Target® Optical, and JCPenney® Optical. In the Humana network, members have:

- ✣ The same benefits at all participating providers, no matter where they're located
- ✣ Wholesale pricing on frames, avoiding high retail markups
- ✣ Simple access to plan information, provider search, Customer Care and other automated services at **HumanaVisionCare.com**
- ✣ Select a vision provider by visiting **HumanaVisionCare.com**, or calling **866.537.0229**

Flexible Spending Accounts

Administered by TASC

A Flexible Spending Account (FSA) is a great way to handle any medical expenses not covered by your medical insurance, or your dependent day care expenses. You make regular, pre-tax contributions to your account through payroll. This means you'll pay less in taxes and overall, have more money to spend and save.

Healthcare FSA Annual Maximum	$3,050
Healthcare FSA Annual Minimum	$200
Dependent Day Care FSA Annual Maximum*	$5,000

*If you are married filing jointly, or single and file Head of Household.

Here's How an FSA Works

1. You decide the annual amount you want to contribute to either or both FSAs based on your expected healthcare and/or dependent childcare/elder care expenses.
2. Your contributions are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA.
3. You can pay with the Healthcare FSA debit card for eligible healthcare expenses. For dependent care, you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim online.
4. You must save all receipts in case you are contacted by TASC to provide more detail about a specific transaction.

YOU MUST RE-ELECT THE AMOUNT YOU WANT DEFERRED EVERY YEAR DURING ANNUAL ENROLLMENT!

FSA Savings Example

Your Annual Salary	$35,000	
Out-of-Pocket Medical Expenses	$1,000/year	
Out-of-Pocket Dependent Day Care Expenses	$1,500/year	
$2,500 Annual Election	**No FSA**	**With FSA**
Gross Pay	$35,000	$35,000
FSA Contribution (Health and Dependent Care)	- $0	- $2,500
Taxable Income	$35,000	$32,500
Taxes at 25%	- $8,750	- $8,125
Out-of-Pocket Expense	- $2,500	- $2,500
Reimbursement from FSA	+ $0	+ $2,500
Take Home Pay	**$23,750**	**$24,375**
Savings!	$0	$625!

The plan year for FSAs is September 1 through August 31. Take this into account when estimating your expenses. If you haven't used all of the money in your FSAs by the end of the plan year, you cannot carry over that money to the next year. See handbook details for information on the grace period.

Life and Accidental Death & Dismemberment

Administered by Lincoln Financial

Life Insurance

Basic Benefit

One-hundred percent of your base annual salary, with a minimum benefit of $7,500 and a $500,000 maximum. Included is an Accidental Death and Dismemberment (AD&D) plan.

Reductions

Your Basic Life Insurance benefit will be reduced as follows:

Less than age 70	No benefit reduction
At age 70	Benefits will reduce by 35% of the original amount.
At age 75	Benefits will reduce an additional 15% of the original amount

Continuation

This coverage may be continued according to the terms of this policy when covered persons are no longer working due to:

- a total disability (only upon approval of waiver of premium);
- an approved leave of absence (other than for military service);
- a temporary lay-off; or
- an approved sabbatical leave.

Beneficiaries

A beneficiary is the person you designate to receive life benefits should you die while you are covered. You will need to designate your beneficiary during the benefits enrollment process. You may change your beneficiary choice at any time, and we encourage you to check your beneficiaries at least once a year.

Accidental Death & Dismemberment (AD&D) Insurance

(This benefit applies to the insured employee only)

You are eligible for this benefit if you are accidentally injured while your insurance is in effect and the injury directly results in one of the following total losses which occurs: 1) without other causes; and 2) within 365 days of the accident.

Benefit (Principal Sum)

One-hundred percent of your base annual salary, with a minimum benefit of $7,500 and a $500,000 maximum.

Dependent Term Life

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

Group Universal Life Insurance

Administered by Minnesota Life Insurance Company

What is Group Universal Life Insurance?

Group Universal Life Insurance (GUL) is a group life insurance plan that offers the added advantage of a Cash Accumulation Fund, making it a flexible financial planning tool. Participants may adjust their life insurance coverage and the amount of their contributions to the Cash Accumulation Fund as their needs change. Money in the Cash Accumulation Fund earns a competitive interest rate that grows income tax-deferred. You have access to your money at any time through loans or withdrawals. Loans and withdrawals will reduce both the policy cash value and death benefit.

Eligibility

For initial coverage or increases in coverage to become effective, the employee must be actively at work on the initial effective date and their spouse and children must not be hospitalized or confined because of illness or disease.

	Employee	Spouse/Domestic Partner	Children
Coverage Increments	$10,000	$10,000	$5,000 or $10,000 term insurance
Coverage Maximum	The lesser of 5x your annual salary rounded to the next higher $10,000 or $1,000,000	The lesser of 3x the employee's annual salary rounded to the next higher $10,000 or $100,000	Convertible to full GUL coverage up to five times the term amount due to loss of dependent eligibility
Coverage Maximum for newly hired / newly eligible employees who enroll within 31 days after becoming eligible	The lesser of 2x your annual salary rounded to the next higher $10,000 or $200,000	$10,000	
Medical Question Limit at Annual Enrollment without health questions	If you're not currently enrolled in the GUL plan: you may elect coverage in increments of $10,000, up to a maximum of the lesser of 1x your annual salary, rounded to the next higher $10,000, or $100,000 If you are currently enrolled in the GUL plan, you may increase coverage in increments of $10,000 by 1x your annual salary, rounded to the next higher $10,000, up to $200,000 or 2x times you annual salary, rounded to the next higher $10,000, whichever is less	A medical statement is required for any amount of coverage	N/A
Medical Question Limit at a Qualifying Event without health questions	May elect or increase coverage one $10,000 increment, up to a new total maximum of the lesser of 2x your annual salary rounded to the next higher $10,000, or $200,000	A medical statement is required for any amount of coverage	N/A

Duplication of Coverage

An employee cannot also be covered as a spouse/domestic partner or child of another employee. A child may only be covered by one parent if both are employees of Orange County Public Schools (OCPS).

Disability

Administered by Lincoln Financial

What Is Disability Insurance?

Disability insurance replaces a portion of your income if you become disabled and unable to work. You may select the benefit level you wish to receive, and your premiums will be based on the level of protection you select.

Underwriting Guidelines

New Hires: New Hires can sign up for coverage within 60 days of their date of hire and receive up to a $7,500 monthly benefit (not to exceed 66 2/3 percent of monthly salary) without evidence of insurability. The pre-existing condition limitation applies to the full amount of coverage.

Currently Insured Employees: During the approved annual enrollment period, currently insured employees can increase their amount of coverage up to 66 2/3 percent of monthly salary without evidence of insurability. The pre-existing condition limitation applies to the increased amount of coverage including any reduction made to the elimination (waiting) period.

Late Entrants: During the approved annual enrollment period, active full-time employees can sign up for coverage and receive up to a $7,500 monthly benefit (not to exceed 66 2/3 percent of monthly salary) without evidence of insurability. The pre-existing condition limitation applies to the full amount of coverage.

Benefit Amount

You may purchase a monthly benefit in $100 increments, starting at a minimum of $200, up to 66 2/3 percent of your monthly earnings to a maximum monthly benefit of $4,000 and in $500 increments thereafter up to a maximum monthly benefit of $7,500.

Elimination Period (Waiting Period)

The Elimination Period is the length of time of continuous disability, due to sickness or injury, which must be satisfied before you are eligible to receive benefits. You may choose an Elimination Period of 14, 30, 60 or 180 days.

Applies to Elimination Periods of 14 and 30 days ONLY– If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement. Inpatient means that you are confined to a hospital room due to your sickness or injury for eight or more consecutive hours.

Duration of Benefits

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

Age At Disability Period	Maximum Benefit Period
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Pregnancy Benefit

Disability due to pregnancy or complications of pregnancy will be covered on the same basis as a sickness.

Pre-Existing Condition Exclusion

The plan will not cover any disability that begins in the first 12 months after your effective date of coverage that is caused by, contributed to by, or resulting from a pre-existing condition.

A pre-existing condition is a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three (3) months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

Employee Contributions for Benefits

Deductions are taken biweekly over 10 months September through June) for 12 months of coverage.

MEDICAL – LOCAL PLUS (A)

	Monthly	Biweekly
Employee	OCPS-Paid	
Employee + Spouse / Same-Sex Domestic Partner (DP)	$352.24	$176.12
Employee + Children	$70.46	$35.23
Family	$422.70	$211.35
Half-Family	OCPS-Paid	
Part-Time Employee Only	$464.44	$232.22

MEDICAL – HRA (B)

	Monthly	Biweekly
Employee	$52.54	$26.27
Employee + Spouse / Same-Sex Domestic Partner (DP)	$1,183.70	$591.85
Employee + Children	$850.36	$425.18
Family	$1,494.70	$747.35
Half-Family	$282.94	$141.47
Part-Time Employee Only	$516.98	$258.49

MEDICAL – OAPIN (C)

	Monthly	Biweekly
Employee	$52.54	$26.27
Employee + Spouse / Same-Sex Domestic Partner (DP)	$826.22	$413.11
Employee + Children	$521.74	$260.87
Family	$1,110.26	$555.13
Half-Family	$90.72	$45.36
Part-Time Employee Only	$516.98	$258.49

MEDICAL – SUREFIT ADVENTHEALTH AND CVS (D)

	Monthly	Biweekly
Employee	OCPS-Paid	
Employee + Spouse / Same-Sex Domestic Partner (DP)	$352.24	$176.12
Employee + Children	$50.00	$25.00
Family	$400.00	$200.00
Half-Family	OCPS-Paid	
Part-Time Employee Only	$464.44	$232.22

*Part-time employees, add $232.22 to the biweekly dependent rate listed above to obtain your biweekly payroll deduction. The Orange County School Board pays $928.86 per month for each full-time benefited employee. For the 2023-2024 plan year, that equates to $9,288.62.

DENTAL – DELTACARE BASIC

	Biweekly
Employee	$6.24
Employee + 1 Dependent	$10.30
Employee + 2 or More Dependents	$15.24

DENTAL – DELTACARE COMPREHENSIVE

	Biweekly
Employee	$10.20
Employee + 1 Dependent	$19.08
Employee + 2 or More Dependents	$23.35

DENTAL – DELTA DENTAL PPO

	Biweekly
Employee	$22.23
Employee + 1 Dependent	$38.17
Employee + 2 or More Dependents	$54.59

VISION

	Biweekly
Employee Only	$3.32
Employee + Dependents	$9.20

Term Life Insurance

A. **Employer-Only Life Insurance – 100% OCPS-Paid**

B. **Dependent Life Insurance Biweekly Premium**

Class	Biweekly	Base Salary
Class I	$1.69	$20,000 or more
Class II	$1.26	less than $20,000
Class III	$0.85	less than $15,000
Class IV	$0.63	less than $10,000

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

Age	Biweekly Payroll Deduction for Each $10,000
Under 25	$0.22
25-29	$0.27
30-34	$0.35
35-39	$0.39
40-44	$0.44
45-49	$0.67
50-54	$0.99
55-59	$1.85
60-64	$2.84
65-69	$5.46
70-74	$8.85

Child Term Insurance Rider Available: Monthly rate for $5,000 = $.92 for all eligible dependent children; Monthly rate for $10,000 = $1.84 for all eligible dependent children. Premiums payable may be subject to minor adjustments (upwards and downwards) due to rounding of rates. Please contact Minnesota Life at 800.843.8358 to determine actual premiums due.

Disability Insurance

Minimum Annual Salary	Accident and Illness Monthly* Disability Benefits	When Accident and Illness Benefits Begin after:							
		14 Days		30 Days		60 Days		180 Days	
		Monthly Rate	Biweekly Rate	Monthly Rate	Biweekly Rate	Monthly Rate	Biweekly Rate	Monthly Rate	Biweekly Rate
$3,600	$200	$5.76	$2.88	$4.32	$2.16	$3.24	$1.62	$2.20	$1.10
$5,400	$300	$8.64	$4.32	$6.48	$3.24	$4.86	$2.43	$3.30	$1.65
$7,200	$400	$11.52	$5.76	$8.64	$4.32	$6.48	$3.24	$4.40	$2.20
$9,000	$500	$14.40	$7.20	$10.80	$5.40	$8.10	$4.05	$5.50	$2.75
$10,800	$600	$17.28	$8.64	$12.96	$6.48	$9.72	$4.86	$6.60	$3.30
$12,600	$700	$20.16	$10.08	$15.12	$7.56	$11.34	$5.67	$7.70	$3.85
$14,400	$800	$23.04	$11.52	$17.28	$8.64	$12.96	$6.48	$8.80	$4.40
$16,200	$900	$25.92	$12.96	$19.44	$9.72	$14.58	$7.29	$9.90	$4.95
$18,000	$1,000	$28.80	$14.40	$21.60	$10.80	$16.20	$8.10	$11.00	$5.50
$19,800	$1,100	$31.68	$15.84	$23.76	$11.88	$17.82	$8.91	$12.10	$6.05
$21,600	$1,200	$34.56	$17.28	$25.92	$12.96	$19.44	$9.72	$13.20	$6.60
$23,400	$1,300	$37.44	$18.72	$28.08	$14.04	$21.06	$10.53	$14.30	$7.15
$25,200	$1,400	$40.32	$20.16	$30.24	$15.12	$22.68	$11.34	$15.40	$7.70
$27,000	$1,500	$43.20	$21.60	$32.40	$16.20	$24.30	$12.15	$16.50	$8.25
$28,800	$1,600	$46.08	$23.04	$34.56	$17.28	$25.92	$12.96	$17.60	$8.80
$30,600	$1,700	$48.96	$24.48	$36.72	$18.36	$27.54	$13.77	$18.70	$9.35
$32,400	$1,800	$51.84	$25.92	$38.88	$19.44	$29.16	$14.58	$19.80	$9.90
$34,200	$1,900	$54.72	$27.36	$41.04	$20.52	$30.78	$15.39	$20.90	$10.45
$36,000	$2,000	$57.60	$28.80	$43.20	$21.60	$32.40	$16.20	$22.00	$11.00
$37,800	$2,100	$60.48	$30.24	$45.36	$22.68	$34.02	$17.01	$23.10	$11.55
$39,600	$2,200	$63.36	$31.68	$47.52	$23.76	$35.64	$17.82	$24.20	$12.10
$41,400	$2,300	$66.24	$33.12	$49.68	$24.84	$37.26	$18.63	$25.30	$12.65
$43,200	$2,400	$69.12	$34.56	$51.84	$25.92	$38.88	$19.44	$26.40	$13.20
$45,000	$2,500	$72.00	$36.00	$54.00	$27.00	$40.50	$20.25	$27.50	$13.75
$46,800	$2,600	$74.88	$37.44	$56.16	$28.08	$42.12	$21.06	$28.60	$14.30
$48,600	$2,700	$77.76	$38.88	$58.32	$29.16	$43.74	$21.87	$29.70	$14.85
$50,400	$2,800	$80.64	$40.32	$60.48	$30.24	$45.36	$22.68	$30.80	$15.40
$52,200	$2,900	$83.52	$41.76	$62.64	$31.32	$46.98	$23.49	$31.90	$15.95
$54,000	$3,000	$86.40	$43.20	$64.80	$32.40	$48.60	$24.30	$33.00	$16.50
$55,800	$3,100	$89.28	$44.64	$66.96	$33.48	$50.22	$25.11	$34.10	$17.05
$57,600	$3,200	$92.16	$46.08	$69.12	$34.56	$51.84	$25.92	$35.20	$17.60
$59,400	$3,300	$95.04	$47.52	$71.28	$35.64	$53.46	$26.73	$36.30	$18.15
$61,200	$3,400	$97.92	$48.96	$73.44	$36.72	$55.08	$27.54	$37.40	$18.70
$63,000	$3,500	$100.80	$50.40	$75.60	$37.80	$56.70	$28.35	$38.50	$19.25
$64,800	$3,600	$103.68	$51.84	$77.76	$38.88	$58.32	$29.16	$39.60	$19.80
$66,600	$3,700	$106.56	$53.28	$79.92	$39.96	$59.94	$29.97	$40.70	$20.35
$68,400	$3,800	$109.44	$54.72	$82.08	$41.04	$61.56	$30.78	$41.80	$20.90
$70,200	$3,900	$112.32	$56.16	$84.24	$42.12	$63.18	$31.59	$42.90	$21.45
$72,000	$4,000	$115.20	$57.60	$86.40	$43.20	$64.80	$32.40	$44.00	$22.00
$81,000	$4,500	$129.60	$64.80	$97.20	$48.60	$72.90	$36.45	$49.50	$24.75
$90,000	$5,000	$144.00	$72.00	$108.00	$54.00	$81.00	$40.50	$55.00	$27.50
$99,000	$5,500	$158.40	$79.20	$118.80	$59.40	$89.10	$44.55	$60.50	$30.25
$108,000	$6,000	$172.80	$86.40	$129.60	$64.80	$97.20	$48.60	$66.00	$33.00
$117,000	$6,500	$187.20	$93.60	$140.40	$70.20	$105.30	$52.65	$71.50	$35.75
$126,000	$7,000	$201.60	$100.80	$151.20	$75.60	$113.40	$56.70	$77.00	$38.50
$135,000	$7,500	$216.00	$108.00	$162.00	$81.00	$121.50	$60.75	$82.50	$41.25

*The monthly disability benefit level reflected in this chart is an average benefit. The actual amount paid varies since the monthly benefit is calculated on an annual basis to determine the weekly benefit that is payable by Lincoln. The benefit is based on 52 weeks in a year and is dependent on the number of days in the associated month.

Contact Information

If you have specific questions about any of the benefit plans, please contact the administrator listed below, or your local Human Resources department.

Benefit	Carrier	Phone	Website
Medical All Plans	Cigna	800.244.6224	www.cigna.com
Pharmacy	CVS / Caremark	800.378.9264	www.caremark.com
Dental Basic and Comprehensive	DeltaCare® USA	800.422.4234	www.deltadentalins.com
Dental PPO	Delta Dental	800.521.2651	www.deltadentalins.com
Vision	Humana Specialty Benefits	877.398.2980	www.humanavisioncare.com
Disability	Lincoln Financial Group	800.423.2765	www.lfg.com
Group Universal Life	Minnesota Life Insurance	800.843.8358	www.lifebenefits.com
Flexible Spending Accounts	Total Administration Services Corporation (TASC)	800.422.4661	www.tasconline.com
Benefits Advocate Center	Gallagher Benefit Services	833.416.5130	Email bac.ocps@ajg.com for assistance
Employee Assistance Program	Cigna	877.622.4327	www.mycigna.com. If you are not covered by one of the OCPS Cigna plans, use Employer ID: ocps
Employee Wellness Program	OCPS	407.317.3200, Ext. 2002929	http://insurance.ocps.net Select “Employee Wellness” from the left side of the page.
OCPS Insurance Benefits	OCPS	407.317.3245	http://insurance.ocps.net

Legal Notices

Initial Notice Regarding HIPAA's Special Enrollment Provision

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

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

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

New Dependent by Marriage, Birth, Adoption, or Placement For Adoption
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility For Medicaid or a State Children's Health Insurance Program (CHIP)

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.766.9012
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 617.886.8102
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

Newborns and Mothers Health Protection Act

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

Woman's Health and Cancer Rights

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

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymphedemas In addition, the plan may not:
  - interfere with a woman's rights under the plan to avoid these requirements,or
  - offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

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

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage under a QMCSO

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

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

Coverage of Students on Medically Necessary Leave of Absence (Michelle's Law)

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

Coverage will terminate on the earlier of:

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

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

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

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

Notice of Federal Requirements Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

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

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence. For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows: You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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

Notice of Opt-Out Status for Mental Health Services

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

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

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

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

Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

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

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

The exemption from these Federal requirements was initially in effect for 2010-2011 plan year beginning October 1, 2010 and ending September 30, 2011, continued through the 2011-2012, 2012-2013, 2013-2014, 2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2020, and 2020-2023 plan years and is being renewed for the subsequent 2023-2024 plan year beginning October 1, 2023 and ending September 30, 2024. The election may be renewed for subsequent plan years.

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

OCPS Grievance Procedure

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

Notice Regarding Wellness Program

The U.S. Equal Employment Opportunity Commission requires employers that offer a wellness program provide a notice to employees informing them what information is collected, how it is used, who receives it and what is done to keep it confidential. Find the OCPS Notice Regarding Wellness Program on the OCPS Internet at **https://www.ocps.net/departments/risk_management/insurance_benefits/**.

Note

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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