2023-2024 Benefit Guide for Retirees

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
- Dental
- Vision
- Life and Accidental Death & Dismemberment
- Group Universal Life Insurance

Eligibility – Retirees

Individuals who have retired from Orange County Public Schools. Retirees may not be covered as a retiree and as a dependent on another OCPS medical plan.

In order to have any coverage, all eligible retirees must complete the enrollment process through TASC.

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.

Retirees must provide documented proof of dependency at the time of enrollment or as requested by TASC. Failure to provide documented proof of dependency will result in termination of the dependent on the last day of the month, following 60 days from the date of notification to the Retiree, by regular U.S. Mail to the Retiree's last known address as shown by the records of TASC.

Eligible dependents include:

1. Spouse (supported by a marriage certificate)
2. The Retiree'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 retiree.
   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 Retiree's "sole spousal equivalent" and not married to or partnered with any other spouse, spousal equivalent or domestic partner.
   e. The retiree 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 Retiree or the covered Retiree'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 Retiree or the covered Retiree'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 Retiree'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 Retiree's domestic partner includes:
   a. A natural child.
   b. A legally adopted child.
   c. A child for whom the covered Retiree's domestic partner has legal guardianship.
   d. A child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order.
   e. A dependent of a currently enrolled dependent (e.g. your grandchild). A newborn child of a covered dependent child is eligible from birth until the end of the month in which the child reaches 18 months of age. Otherwise, grandchildren's eligibility is contingent upon legal guardianship.
5. An adult child covered in 3 and 4 above may continue coverage through the end of the calendar year in which the child attains the age of 30 if the adult child meets all of the following conditions:
   a. Unmarried; and
   b. No dependent children of their own; and
   c. Full-time or part-time student or reside in the State of Florida, if not a student; and
   d. Does not have private insurance coverage and is not eligible for public insurance coverage including coverage under Title XVII of the Social Security Act.

   The premium is equal to the single adult rate for COBRA continuation coverage. 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 Retiree for support and maintenance. Annual documentation is required.

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

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*

OCPS

	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 or independent lab)
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: $20 copay/visit*	Visits 1-5: No charge Visits 6-10: $10 copay/visit* Visits 11-20: $20 copay/visit*	30% after deductible	Visits 1-5: No charge Visits 6-10: $10 copay/visit* Visits 11-20: $20 copay/visit*	Visits 1-5: No charge Visits 6-10: $10 copay/visit* Visits 11-20: $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 retirees 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.

OCPS

Medicare Plans Overview

Once you or your spouse / domestic partner become(s) eligible for Medicare Parts A and B, whether it be because you are 65 years of age or because of a disability, you are eligible for benefits through the Florida School Retiree Benefits Consortium (FSRBC). You must enroll in Medicare Parts A (Hospital) and B (Physician) and one of the FSRBC plans. If any other family members are currently covered under your medical plan and not eligible for Medicare, they can select from the previously described medical plans. All family members must enroll in the same plan. If the OCPS Retiree is Medicare eligible and the other family members are not, ancillary benefits (i.e. dental and vision) will be offered through the FSRBC for the retiree and all dependents. If the spouse / domestic partner or dependent is Medicare eligible and the OCPS Retiree is NOT, ancillary benefits (i.e. dental and vision) for the retiree and all dependents will be offered through TASC and are outlined in this handbook.

FSRBC annual enrollment information is distributed in the fall.

When turning 65 after retirement, bswift (the administrator of FSRBC benefits), will send you a mailing notifying you of your enrollment opportunity. Communications will begin up to one year prior to your 65th birthday. If you have not received information and your 65th birthday is less than three months away, please contact bswift at **833.686.0983**.

OC
PS

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
	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**

OCPS

OCPS-Paid Term Life Insurance

(Including Accidental Death & Dismemberment)

The term life insurance offered by OCPS gives you the opportunity to purchase life insurance while you are a retiree.

Level Premium Term Insurance

You may purchase a $1,000, $5,000, or $10,000 term life insurance policy for yourself. At the time of your retirement, no health questions are required to be eligible for the $1,000 coverage.

Otherwise, health questions are required at all times when electing any of the three term life benefits.

Additional Forms to Complete

Lincoln Financial Application for Life Insurance

Group Universal Life Insurance

(Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group Securian)

Portability

Participating retirees, spouses/domestic partners and dependent children may continue their coverage on a direct-bill basis if the retiree terminates employment or retires after the plan effective date or if a spouse / domestic partners or child no longer meets the eligibility requirement. Minimum rates (cost of insurance) may increase in the future.

For more information regarding portability, please contact Securian at **800.843.8358**.

Retiree Contributions for Benefits

The following are **monthly** rates for retirees who are **not** eligible for Medicare.

Medical

Cigna Plan	Cigna Local Plus OAP In-Network (A)	Cigna Health Reimbursement Account (B)	Cigna Open Access Plus (C)	Cigna SureFit (D)
Retiree Only	$774.05	$817.83	$817.83	$774.05
Retiree + Children	$832.77	$1,482.68	$1,208.83	$815.72
Retiree + Spouse	$1,067.58	$1,760.47	$1,462.57	$1,067.58
Retiree + Children + Spouse	$1,126.30	$2,019.63	$1,699.27	$1,107.38
Spouse Only*	$774.05	$817.83	$817.83	$774.05
Spouse + Children*	$832.77	$1,482.68	$1,208.83	$815.72
Children Only*	$352.25	$664.85	$664.85	$333.33

*When retiree is enrolled in an FSRBC plan.

Dental

	DeltaCare USA Managed Dental Plan Basic	DeltaCare USA Managed Dental Plan Comprehensive	Delta Dental PPO (Preferred Provider Option) Plan
Retiree Only	$10.40	$17.00	$37.05
Retire + 1 Dependent	$17.18	$31.80	$63.61
Retiree + 2 or More Dependents	$25.38	$38.93	$90.98

Vision

	Vision Care Plan
Retiree Only	$5.52
Retiree + Dependents	$15.32

Term Life Insurance

(Rates subject to change)

$1,000	$4.09
$5,000 (health questions required)	$20.45
$10,000 (health questions required)	$40.90

Group Universal Life Insurance

Please refer to the Group Universal Life section of the guide.

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
Term Life	Lincoln Financial Group	800.423.2765	www.lfg.com
Group Universal Life	Minnesota Life Insurance	800.843.8358	www.lifebenefits.com
Retiree Billing	Total Administration Services Corporation (TASC)	800.720.4460	www.tasconline.com
Employee Assistance Program (Available to Retirees)	Cigna	877.622.4327	www.mycigna.com. If you are not covered by one of the OCPS Cigna plans, use Employer ID: ocps
OCPS Insurance Benefits	OCPS	407.317.3245	https://www.ocps.net/departments/risk_management/insurance_benefits
Benefit Advocate Center(BAC)	Gallagher	833.416.5130	bac.ocps@ajg.com

Legal Notices

Notice of Special Enrollment Rights

If you are declining enrollment for your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your dependents' other coverage). However, you must request enrollment within 30 days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact TASC at **800.720.4460**.

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 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 retirees / 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 retirees 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 Retirees 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/**.

This benefit summary prepared by

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