

# **I. GENERAL INSURANCE INFORMATION**

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## A. ENROLLMENT INFORMATION

### ***ELIGIBILITY***

Benefits are generally limited to:

#### ***Employees***

1. All full-time employees working 25 hours or more per week and regular part-time active employees working a minimum of 17.5 hours per week will be eligible for benefits following a waiting period of 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.**

#### ***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 to the Employee, by regular U.S. Mail to the Employee's last known address as shown by the records of OCPS.

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.
  - 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 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.

## ***ENROLLING FOR COVERAGE***

### ***Initial Enrollment***

The initial enrollment period begins when employees hired in an eligible payroll area meet all eligibility requirements. New Employee Enrollment must be completed online through Employee Self-Service within two weeks from the employee's first day of work. 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.

### ***Annual Enrollment***

Each year, employees have the opportunity to make changes to their benefit elections during Annual Enrollment. Current benefit elections will automatically continue unless you complete the Annual Enrollment process online. OCPS typically holds Annual Enrollment in May/June. Refer to the Plan Summaries for details on each benefit. Changes will be effective October 1<sup>st</sup>.

*Note on Flexible Spending Account Elections.* If you participate in the Flexible Spending Accounts (FSA's) you **must** make new elections annually even if you do not want to make a change. FSA elections will be effective September 1<sup>st</sup>.

### ***Mid-year Changes in Enrollment***

All eligible employees and dependents, once enrolled and provided the premium is paid, cannot change their elections in the plan(s) for the remainder of the plan year except under certain circumstances as allowed by HIPAA Special Enrollment Rights or as defined in Section 125 of the Internal Revenue Code (IRC), for example:

- A change in family or employment status,
- A change in cost or coverage for certain benefits.

The change in status must result in an employee, spouse or dependent gaining or losing eligibility for coverage under a plan. Changes must be made by notifying the Insurance Benefits Office within thirty (30) days (unless time frames are specifically noted differently) of the qualifying change in status.

*Note for Newborns and Adoptions.* If notice is provided to the Insurance Benefits Office within thirty (30) days of the birth or placement for adoption, no additional premium (if applicable) will be charged for the first thirty (30) days from birth or placement for adoption. If notice is given more than thirty (30) days but within sixty (60) days of the birth or placement for adoption, you will be charged the additional premium (if applicable) from the date of birth or placement for adoption. If notice is not provided within sixty (60) days of the birth or placement for adoption, you must wait until the next Annual Enrollment or have a qualifying change in status as defined by Section 125 of the Internal Revenue Code.

Refer to Section E. the Summary Plan Description of the Orange County Public Schools Section 125 Plan for more detail.

### ***Note for Domestic Partners and their children***

Employees with coverage for a domestic partner and/or a domestic partner's child(ren) will have post-tax premium deductions. As such, this post-tax coverage can be dropped at any time. Mid-year changes to add a domestic partner or child(ren) of a domestic partner will follow Section 125 guidelines.

### ***TERMINATION OF COVERAGE***

Benefits generally end:

1. The end of the month in which employment ceases\*
2. The first day of any month for which continuous premium payments are not made
3. When dependents are no longer considered eligible under these plans
  - a. Grandchildren who are covered as a dependent of dependent (other than spouse/domestic partner).  
If the parent becomes ineligible during the grandchild's 18 months eligibility period, coverage for both the parent and the child will terminate.
4. When these plans are no longer in force.
5. When the Employee fails to provide documented proof of dependency at enrollment or when requested by the Insurance Benefits department:
  - a. Coverage ends the last day of the month following 60 days from the date of notification to the Employee, by regular U.S. Mail to the Employee's last known address as shown by the records of OCPS.

\*Ten-month employees who resign, retire or are non-reappointed, and completed the school year, will have coverage through the end of August.

**If you are retiring from OCPS and are interested in continuing your coverage, please contact the Insurance Benefits Office prior to your retirement date.**

### ***PLAN YEAR***

October 1 through September 30 of each year.

**NOTE: The plan year for Flexible Spending Accounts (FSA's) is September 1 through August 31 of each year (with a "grace period" of 2 months and 15 days following the end of the plan year).**

### ***LEAVE OF ABSENCE***

Coverage may be continued during an OCPS approved leave of absence. When you are no longer receiving a paycheck and payroll deductions stop, you will be billed for most of the insurance plans\* (including any OCPS Board contributions and the OCPS-paid plans).

\*The Group Universal Life plan is direct-billed from the appropriate company.

### ***FAMILY AND MEDICAL LEAVE ACT INFORMATION***

The Family and Medical Leave Act of 1993 (FMLA) applies to all public agencies and allows eligible employees to take up to 12 weeks of leave for the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

- for any qualifying event due to the employee's spouse, son, daughter or parent being on active duty in the armed services or called to active duty in support of a war or national emergency.

An eligible employee who is a spouse, son, daughter, parent, or "next of kin" (the nearest blood relative) of a member of the armed services may take up to 26 weeks of leave during a single 12 month period to care for a member of the Armed Forces, including a member of the National Guard or Reserves who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness suffered while on active duty.

To be eligible, an employee must be employed by OCPS at least 12 months and have 1,250 hours worked in the 12 months prior to the leave.

Generally, employers covered by the FMLA are required to continue to provide the same individual group health coverage during the leave period, and once the leave period is concluded, to reinstate the employee to the same or equivalent position. In addition, the FMLA provides that an employee taking such a leave shall not lose any benefits (including retirement rights or benefits) that he or she had accrued before the leave. However no retirement credit may be earned during the time an employee is on a FMLA leave.

For questions or more details about the FMLA, please contact the Family Medical Leave Information line at 407.317.3652 (FMLA).

### ***IDENTIFICATION CARDS***

The identification card (ID card) for the medical insurance plan you select will be mailed to your home address. You should present this ID card when you utilize one of the providers/services. You also will receive a separate card for your pharmacy benefit. You should present this card when you have any prescriptions filled at a retail pharmacy.

New plan ID cards are only issued if changes are made in the coverage offered. If your ID card is stolen or misplaced, please contact the appropriate carrier or administrator.

### ***DISCLAIMER***

**The information contained in this handbook is a summary of the coverages for each plan. If there is a conflict between the information in this handbook and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents.**

### ***OCPS EEO NON-DISCRIMINATION STATEMENT***

The School Board of Orange County, Florida, does not discriminate in admission or access to, or treatment or employment in its programs and activities, on the basis of race, color, religion, age, sex, national origin, marital status, disability, genetic information, sexual orientation, gender identity or expression, or any other reason prohibited by law.

The School Board also provides equal access to the Boy Scouts and other designated youth groups. This holds true for all students who are interested in participating in educational programs and/or extracurricular activities.

The following persons have been designated to handle inquiries regarding the non-discrimination policies, reports of alleged violations, concerns about compliance and/or the grievance procedure(s), etc.:

Equal Employment Opportunity (EEO) Office and Title IX:

**Equal Employment Opportunity (EEO) Officer & Title IX:**

Keshara Cowans – Staff Attorney II  
Office of Legal Services  
Ronald Blocker Educational Leadership Center  
445 W. Amelia St. Orlando, FL 32801  
(407) 317-3411

**ADA Coordinator:**

Michael D. Graf – ADA Compliance Officer  
Office of Legal Services  
Ronald Blocker Educational Leadership Center  
445 W. Amelia St. Orlando, FL 32801  
(407) 250-6248

**Section 504:**

Tajuana Lee-Wenze – Director  
ESE Procedures/Compliance  
Ronald Blocker Educational Leadership Center  
445 W. Amelia St. Orlando, FL 32801  
(407) 317-3279

## **B. PLAN OVERVIEWS**

### **MEDICAL INSURANCE**

One of the benefits you receive as an employee of OCPS is medical insurance, once you have satisfied the waiting period. If you are an eligible, full-time, active employee working 25 hours or more per week, a minimum of one plan is available where the Employee only rate is fully paid for you by OCPS. If you are an eligible, part-time, active employee working at least 17.5 hours per week, but less than 25 hours per week, a minimum of one plan is available where 50 percent of the Employee only rate is paid for you by OCPS. You may choose one of the options described below. Medical insurance also is available through payroll deduction for your spouse/domestic partner and/or your eligible children.

#### ***Plan A: Cigna Local Plus OAP In-Network***

When using this plan, you can go to any provider within the network to identify, evaluate and help manage all your healthcare needs. This network is limited to specific providers in central Florida.

#### ***Plan B: Cigna Health Reimbursement Account***

With this plan, you have the option to go to any medical person and facility. However, when choosing the providers in the network, your benefit coverage will be at a greater level than when opting to receive services outside the network.

#### ***Plan C: Cigna OAP In-Network***

When using this plan, you can go to any provider within the network to identify, evaluate and help manage all your healthcare needs.

#### ***Alternative to Medical Insurance***

If you have other qualifying group medical insurance (such as through your spouse) and you do not want the medical insurance offered by OCPS, you **must** select the OCPS paid alternative: Disability and vision coverage.

#### ***Acceptance/Waiver of Medical Insurance***

If you work at least 17.5 hours per week, but less than 25 hours per week, the Board contributes 50 percent of the Employee-only medical insurance rate. Consequently, you have the option to pay the other 50 percent through payroll deduction, enroll in the Alternative to Medical Insurance plan at no cost, or decline the medical insurance.

### **TERM LIFE INSURANCE**

The term life insurance offered by OCPS provides life insurance protection while you are an employee. This coverage will be terminated once you leave employment with OCPS. There are two plans: One is paid for by OCPS, and the other one is available through payroll deduction.

#### ***OCPS-Paid Life Insurance***

OCPS pays your life insurance premium for term insurance which is equal to one times your base annual salary, with a minimum of \$7,500.

**The following option is available to you with the premium deducted from your paycheck:**

#### ***Dependent Term Life Insurance***

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



## **GROUP UNIVERSAL LIFE INSURANCE**

You may purchase additional life insurance coverage in \$10,000 increments. The minimum benefit is \$10,000; the maximum benefit is five times your annual salary rounded to the next higher \$10,000, or \$1,000,000, whichever is less. You also have the ability to make contributions to a Cash Accumulation Fund. New employees will be eligible for up to two times their annual salary rounded to the next higher \$10,000 or \$200,000 whichever is less without health questions. Any additional amount will be subject to health questions.

In addition, coverage for your spouse/domestic partner may be purchased in \$10,000 increments to a maximum of three times your annual salary rounded to the next higher \$10,000 or \$100,000 whichever is less with the availability of a Cash Accumulation Fund. New employees will be eligible to purchase spouse coverage in the amount of \$10,000 without health questions. Any additional amount will be subject to health questions.

A \$5,000 or \$10,000 term life policy may be purchased for eligible dependent children (provided you elect coverage on yourself or your spouse/domestic partner).

During this year's annual enrollment employees who are not currently enrolled in the GUL plan can enroll in \$10,000 increments up to one times their basic annual earnings, rounded to the next higher \$10,000 or \$100,000 whichever is less without health questions. Employees who *are* currently enrolled in the GUL plan can increase coverage in \$10,000 increments up to one times their annual salary rounded to the next higher \$10,000 to a *new total* maximum of two times annual salary rounded to the next higher \$10,000, or \$200,000, whichever is less without health questions.

## **DISABILITY INSURANCE**

Disability insurance helps you to cover your expenses if you are not able to work due to an accident or illness. Available through payroll deduction, you can select a benefit to meet your needs.

You select the benefits from \$200 to \$7,500 that will replace your monthly income up to 66 2/3 percent of your salary. You also choose the waiting period, so that benefits will begin after day(s) 14, 30, 60 or 180. No health questions will be required for this year's annual enrollment or if you are a new employee enrolling during your initial enrollment period. The pre-existing limitation applies. Refer to section *V. Disability* of this handbook for pre-existing condition details.

For employees who are currently enrolled in the disability program, you may choose to increase your monthly benefit up to 66 2/3 percent of salary (\$7,500 plan maximum), in \$100 increments, without health questions. The pre-existing condition limitation applies to the increased amount of insurance including any reduction made to the waiting period.

Benefits begin on the day after the waiting period you have selected (14, 30, 60 or 180 days), and will continue to age 65 or Social Security Normal Retirement Age, whichever is greater, if disability begins before age 65. If disability begins after age 65 please refer to the certificate of coverage for the payment schedule.

## **DENTAL INSURANCE**

Dental insurance is provided to employees and dependents of OCPS through payroll deduction. OCPS provides three different options of quality dental care. You may choose from either two managed care plans or a PPO plan.

### ***DeltaCare® USA Basic Managed Care Dental Plan (HMO Type)***

The main focus of this plan is preventive dentistry and is designed for individuals who currently have healthy teeth and gums. You must use a participating general dentist to receive benefits. If you are referred to a

participating dental specialist, you will receive a 25 percent reduction from usual and customary fees for services performed. There is a \$5 office visit copayment per visit.

***DeltaCare® USA Comprehensive Managed Care Dental Plan (HMO Type)***

If you select this plan, you will be able to receive regular checkups, cleanings and x-rays. Most of these preventative services are covered at no charge after the \$5 office visit copayment. A benefits and copayment schedule is enclosed that shows the amount you will be responsible to pay. To be eligible for this plan, you will need to select a dentist from the enclosed list. If you are referred to a participating dental specialist, you will pay no more than what is listed in the schedule. Orthodontic care also is a covered benefit. There is little paperwork with this plan, and there are no maximum benefit restrictions with the exception of orthodontia and accidental injury to the sound natural teeth.

***Delta Dental PPO (Preferred Provider Organization) Dental Plan***

You may select any dentist you wish under this plan. However, if you choose a preferred dentist from the PPO dental plan list, you receive greater coverage and have lower out-of-pocket costs. The enclosed schedule of benefits shows the maximum amount the PPO dentist will be reimbursed for each procedure code. You will be responsible for any applicable deductible and/or coinsurance amounts. **With this plan the maximum benefit each year is \$1,300.** For procedures that are not diagnostic and preventive, there is a \$25 calendar year deductible (maximum \$75 per family) when using the **in-network** PPO dentists and a \$50 calendar year deductible (maximum \$150 per family) when using the **out-of-network** dentists.

***Orthodontic Discount Program for Employees***

You and your family are eligible to receive discounts on Orthodontics through this plan. There is no monthly premium and it is not necessary to complete any enrollment forms. Upon showing proper proof that you are employed by OCPS, you and any dependent can receive the 25% discount on Orthodontics. The participating orthodontist will ask for proper proof of employment with OCPS. To receive a list of participating orthodontists, please call 407.660.9034 **and leave your name and email address.**

***Vision Discount Program for Employees***

You and your family are eligible to receive a courtesy discount on vision care up to 35%. There are no monthly premiums and it is not necessary to complete any enrollment forms.

Visit [www.eyemedvisioncare.com/deltadental](http://www.eyemedvisioncare.com/deltadental) to print an ID card and get a list of participating EyeMed providers or call 1.866.246.9041. When scheduling your appointment, inform the office that you are an EyeMed member with a Delta Dental discount plan. Present your printed ID card at your appointment to receive discounted services.

***Plan Administration***

DeltaCare® USA Basic and Comprehensive Managed Care Plans:

Private Medical-Care, Inc.  
1130 Sanctuary Parkway, Suite 600  
Alpharetta, GA 30009  
800.422.4234

Delta Dental PPO (Preferred Provider Organization) Plan:

Delta Dental Insurance Company  
Attn: Professional Services Dept.  
1130 Sanctuary Parkway, Suite 600  
Alpharetta, GA 30009  
800-521-2651

## **VISION INSURANCE**

Being an employee of OCPS gives you the opportunity to purchase vision insurance through payroll deduction. If you select the Humana Specialty Benefits Vision Plan, you receive prepaid services for routine eye care – vision exam plus glasses (lenses and frames) or contacts – through a nationwide network, including more than 1,000 eye doctors in Florida.

## **FLEXIBLE SPENDING ACCOUNTS**

Flexible Spending Accounts (FSAs) allow you to make payroll deductions on a pre-tax basis to pay for certain eligible health and/or dependent care expenses. There are two types of FSAs: One is for healthcare expenses and is called a “Medical Flexible Spending Account.” The other is for dependent care expenses and is called a “Dependent Care Flexible Spending Account.” The accounts are treated separately – you may participate in either or both accounts, but may not transfer funds between accounts. When you enroll you designate how much you want to put into your account for the upcoming plan year. The plan is “use it or lose it.” That is, if you haven’t used all of the money in your Flexible Spending Accounts by the end of the plan year, you cannot carry over that money to the next year. Any unused funds will be forfeited.

Domestic partners and their children are not considered eligible dependents for purposes of FSA participation in accordance with IRS rules.

### C. FREQUENTLY CALLED PHONE NUMBERS

Cigna (For All Cigna Medical Plans)	1.800.244.6224
CVS/Caremark	1.800.378.9264
DeltaCare® USA Managed Dental Plans	1.800.422.4234
Delta Dental PPO (Preferred Provider Organization) Dental Plan	1.800.521.2651
Employee Assistance Program	1.877.622.4327
Employee Wellness Program	407.317.3200, Ext. 2002929
Humana Specialty Benefits Vision Plan	1. 877.398.2980
Lincoln Financial Group Disability Plan	1.800.423.2765
Minnesota Life Insurance Group Universal Life	1.800.843.8358
OCPS Insurance Benefits Office	407.317.3245
Total Administration Services Corporation (TASC)	1.800.422.4661

## D. WEBSITES (FOR PROVIDER DIRECTORIES)

Plan A: Cigna Local Plus OAP In-Network

[www.cigna.com](http://www.cigna.com)

Choose **Find A Doctor**. Click on the **Plans through your employer or school...** link, enter a search location, then click the down arrow at **Select a Plan**, choose **LocalPlus**. In the **Search** box, enter the provider's name, specialty or type of service. Click **Search**.

Plan B: Cigna Health Reimbursement Account

[www.cigna.com](http://www.cigna.com)

Choose **Find A Doctor**. Click on the **Plans through your employer or school ...** link, enter a search location, then click the down arrow at **Select a Plan**, choose **Open Access Plus, OA Plus, Choice Fund OA Plus**. In the **Search** box, enter the provider's name, specialty or type of service. Click **Search**.

*Please note, when looking for a specialist, the copay is reduced from \$65 to \$45 when you choose a Cigna Care Designation provider.*

Plan C: Cigna OAP In-Network

[www.cigna.com](http://www.cigna.com)

Choose **Find A Doctor**. Click on the **Plans through your employer or school ...** link, enter a search location, then click the down arrow at **Select a Plan**, choose **Open Access Plus, OA Plus, Choice Fund OA Plus**. In the **Search** box, enter the provider's name, specialty or type of service. Click **Search**.

Cigna Behavioral Health

[www.cigna.com](http://www.cigna.com)

Choose **Find A Doctor**. Under **Additional Directories**, choose **Cigna Behavioral Directory**. Choose **Provider Directory**.

CVS/Caremark

[www.caremark.com](http://www.caremark.com)

Total Administration Services Corporation (TASC)

[www.tasconline.com](http://www.tasconline.com)

DeltaCare® USA Managed Dental Plans

[www.deltadentalins.com](http://www.deltadentalins.com)

Under **Find a Dentist**, select your plan network, **DeltaCare USA** (for the DeltaCare Basic or Comprehensive plans). Select your state, then your city or zip code.

Delta Dental PPO (Preferred Provider Organization) Dental Plan

[www.deltadentalins.com](http://www.deltadentalins.com)

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

Humana Specialty Benefits Vision Plan

[www.humanavisioncare.com](http://www.humanavisioncare.com)

Select **HumanaVision VCP provider locator**. Enter your address or zip code. Click **Search**.

**E. SUMMARY PLAN DESCRIPTION OF THE  
ORANGE COUNTY PUBLIC SCHOOLS SECTION 125 PLAN**

Plan Name: The Cafeteria Plan of the School Board of Orange County

Plan Type: Premium Conversion Plan

Effective Date of the Plan: April 1, 1989

Company, Plan Sponsor, and Plan Administrator: The School Board of Orange County, Florida

Address: 445 W. Amelia Street, Orlando, FL 32801

Phone Number: 407.317.3200

Employer Identification Number: 59-6000771 Plan Number: 502

The Plan Administrator is designated as the agent for all purposes of legal process.

1. What is the Section 125 Plan?

- a. The OCPS Section 125 Plan, officially known as The Cafeteria Plan of the School Board of Orange County, allows you to purchase certain optional insurance coverage with pre-tax dollars. Federal income tax and social security taxes are not deducted from the amount you pay in premiums on a pre-tax basis under the Section 125 Plan. Your take home pay will be higher by participating in the Section 125 Plan compared to purchasing the same insurance coverage with after tax dollars.

**Federal Tax Implications for Dependent Coverage**

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance that does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

2. What benefits are available to me?

- a. Under the Section 125 Plan the following optional insurance benefits are available to you:
- (1) Medical Insurance
    - (a) Dependent
    - (b) Part-time employee
  - (2) Term Life Insurance up to \$50,000
  - (3) Dental Insurance
  - (4) Vision Insurance
  - (5) Flexible Spending Accounts

- b. Each insurance benefit that is offered under the plan is explained in separate sections of the OCPS Handbook. Additional information is available through the OCPS Insurance Benefits Office.
- c. OCPS has the right to terminate, suspend, withdraw or modify the plan benefits at any time, subject to the provisions of the insurance contracts which provide these benefits. Any failure of insurance benefits, whether due to OCPS's negligence, gross neglect, or otherwise, including failure to enroll a participant or pay premiums, shall not result in any liability by OCPS to a participant.
- d. Your coverage terminates when you leave employment, if you are no longer eligible under the terms of any insurance policy, or when insurance coverage terminates, whichever happens first.
- e. Any benefits provided by insurance shall be provided only after (1) you have given OCPS the necessary information to apply for insurance, and (2) the insurance is in effect for you. 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.

3. How do I join?

- a. You may join the Section 125 Plan on the date you become eligible to participate in the optional insurance benefits available to you under the Section 125 Plan. You will automatically be enrolled in the Section 125 Plan unless you complete the enrollment process on Employee Self-Service and deselect the "Pre-Tax Deductions" box in each of the eligible plans to decline the Section 125 Plan.
- b. You may also join or terminate from the Section 125 Plan during the Annual Enrollment period that is held no later than thirty (30) days before the start of the Plan Year.

4. How does the Section 125 Plan work once I join?

- a. Your decision to participate in the Section 125 Plan cannot be changed during the Plan Year except under certain circumstances as allowed by the Internal Revenue Code (IRS) and permitted by the Section 125 Plan, such as
  - 1. a change in family or employment status,
  - 2. a change in cost or coverage for certain benefits, or
  - 3. a change that gives rise to special enrollment rights under HIPAA.

The change in status must result in an employee, spouse or dependent gaining or losing eligibility for coverage under a plan. See below for details.

- b. Your share of the premiums for the eligible optional insurance benefits you selected will be deducted from your paycheck before federal taxes are taken. The amount of reduced compensation is equal to your share of the premiums charged in your share of the cost.
- c. If you do not complete the enrollment process through Employee Self-Service during the Annual Enrollment period, you will automatically be enrolled for the next plan year (This does not apply to the Flexible Spending Accounts. You must enroll each year).

5. Can I change my insurance benefit elections during the plan year?

a. No, you cannot change your insurance benefit elections during the plan year; however, there is an exception for a documented change in status as allowed under Section 125 of the Internal Revenue Code.

(1) You may add coverage for the following reasons: (generally within 30 days of the qualifying event, unless otherwise noted)

- Marriage/Divorce
- Death of a spouse if coverage is lost under spouse's plan
- Birth, adoption of a child or placement for adoption
- Court Order, Judgment or Decree affecting a dependent child
- Change in employment status of the employee resulting in the eligibility for coverage (i.e. increase in work hours, switch between part-time and full time or return from an unpaid leave of absence)
- Change in employment status of the employee's spouse or the employee's dependent resulting in a loss of coverage under another group plan (i.e. termination of employment, a strike or lockout, commencement of an unpaid leave of absence, reduction in work hours)
- An event that causes an employee's dependent child to satisfy eligibility requirements for coverage, such as, due to the student status or change in parental support and maintenance
- The entire COBRA coverage period has been exhausted
- No longer reside, live or work in the other plan's HMO service area that affects eligibility for coverage under the HMO, and no other coverage is available under the other plan
- If you or your dependent's coverage is terminated in your dependent's other plan during the Annual Enrollment period when the other coverage is on a different plan year
- Loss of eligibility resulting in a loss of coverage under Medicare, educational institution, medical care program of an Indian Tribal government, foreign government group health plan or a State health benefits risk pool.
- Loss of eligibility resulting in a loss of coverage under Medicaid or a State Children's Health Insurance program ("CHIP") if you request enrollment within 60 days after the date you lose eligibility.
- You and/or your dependents become eligible under Medicaid or a CHIP plan for assistance with respect to paying for premiums under the plan if you request enrollment within 60 days after you become eligible for such premium assistance.
- Loss of Marketplace eligibility because the insurer dropped the individual product line, dropped a specific plan design (e.g. HDHP, PPO, HMO), dropped out of the individual market in a state or the insurer stops offering the product at the end of the year. Loss of eligibility due to nonpayment of individual policy premiums and loss of individual coverage due to fraud do not apply.

(2) You may drop coverage for the following reasons: (Within 30 days of the change becoming effective)

- Divorce/Marriage
- Death of a dependent
- Court Order, Judgment or Decree that requires the spouse, former spouse or other individual to provide coverage for a dependent child



- Commencement of a dependent’s employment that results in eligibility for coverage with his/her employer
  - Dependent is newly eligible for group health plan coverage through his/her employer or college-student insurance.
  - An event that causes an employee’s dependent child to cease to satisfy the requirements for coverage, such as, due to the attainment of age, student status or change in parental support and maintenance
  - Change in employment status resulting in a loss of eligibility for coverage (i.e. termination of employment, change in work schedule, reduction of hours, commencement of an unpaid leave of absence)
  - If you or your covered dependents enroll for coverage in another plan provided by his/her employer during the Annual Enrollment period when the other coverage is on a different plan year
  - Entitlement to a Government Program (Medicaid or Medicare)
  - As a result of a Court Order, Judgment or Decree affecting a dependent child, if the spouse, former spouse or other individual in fact provides the required coverage for a dependent child
  - Enrollment in a Qualified Health Plan (QHP) during the Marketplace annual open enrollment – The end of OCPS coverage must correspond with the enrollment in a QHP through the Marketplace. Coverage under the Marketplace QHP must be effective no later than the day immediately following the last day OCPS coverage ends.
- b. In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a “change in status” if your dependent no longer meets the qualifications to be eligible for dependent care.
- c. There are detailed rules on when a change in election is deemed to be consistent with a “change in status.” In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Insurance Benefits Office.
- d. If the cost of a benefit provided **under the Plan** increases or decreases significantly during a Plan Year, you are permitted to make a mid-year election change. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or elect coverage under another benefit package option with similar coverage, or revoke your election entirely if no similar plan is available. If the cost decreases significantly, you will be permitted to either make the corresponding changes in your payments, switch to this lower cost plan from a more costly plan option or elect this coverage if previously not enrolled.
- e. If you have a significant curtailment of coverage during a Plan Year, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally. For example, there is a significant increase in the deductible, the copayment and the out of pocket cost sharing limit. If you lose coverage due to the elimination of an existing benefits package option during a Plan Year, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage or drop coverage if no similar benefit package option is available. In addition, if we add a new coverage option or significantly improve an existing benefit package option, you may elect to receive, on a prospective basis,

coverage under the new or improved benefit package option (whether or not you have previously elected coverage under the plan).

- f. If your spouse or dependent has a significant curtailment of coverage and no other plan with similar coverage is offered in another plan during a Plan Year, then you may revoke your elections and elect, on a prospective basis, to add your spouse and/or dependents to your existing coverage. Coverage under another plan is significantly curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally and no similar benefit option is available. For example, there is a significant increase in the deductible, the copayment and the out of pocket cost sharing limit. In addition, if your spouse and/or dependent loses coverage due to the elimination of an existing benefits package option (with no similar coverage available) during a Plan Year, then you may revoke your elections and elect, on a prospective basis, to add your spouse and/or dependents to your existing coverage.
  - g. These rules on change due to cost or coverage do not apply to the Medical Flexible Spending Account, and you may not change your election to the Medical Flexible Spending Account if you make a change due to cost or coverage for insurance.
  - h. You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.
  - i. Any new election will be effective at the time OCPS prescribes. The revocation and new benefit election must be consistent with the respective insurance benefit plan limitations and requirements.
  - j. You are required to contact the Insurance Benefits office, provide documented proof of the status change and complete the add/drop process in Employee Self-Service. Proof of the status change must be provided within thirty (30) days of the qualifying event that caused the family status change.
  - k. Elections made under this Plan will automatically terminate on the date you cease to be a participant in the Plan.
6. How will the Section 125 Plan affect my social security and retirement benefits?
- a. Selection of tax-free benefits under the Section 125 Plan will normally result in you and OCPS making lower contributions to the federal Social Security System. This could reduce your benefits. In addition, other benefits based on taxable compensation could be reduced.
  - b. Your Florida Retirement System benefits are not affected.
7. How do I claim my rights under the Section 125 Plan?
- a. If you believe you are being denied any rights or benefits under the Section 125 Plan, you may file a claim in writing with OCPS. If the claim is wholly or partially denied, OCPS will notify you of the decision in writing. The notification will contain the following:
    - (1) Specific reasons for the denial;
    - (2) Specific reference to pertinent plan provisions;
    - (3) A description of any additional material or information necessary for you to perfect such claim and an explanation of why the material or information is necessary; and
    - (4) Information of the steps to take if you wish to submit a request for review.

- b. This notification will be given within 30 days after the claim is received by OCPS (or within 45 days, if special circumstances require an extension of time for processing the claim). If notification is not given within these periods, the claim will be considered denied as of the last day of the period and you may request a review of your claim.
- c. Within 180 days after you receive written notice of a denied claim (or, if applicable, within 180 days after the denial is considered to have occurred), you (or your duly authorized representative) may;
  - (1) file a written request with OCPS for a review of your denied claim and of pertinent documents; and
  - (2) submit written issues and comments to OCPS.
- d. OCPS will notify you of its final decision in writing. This notification will contain specific reasons for the decision as well as specific references to pertinent plan provisions. The decision will be made within 60 days after the request for review is received by OCPS. If the decision regarding the review is not made within such period, the claim will be considered denied.

## F. CONTINUATION OF HEALTH COVERAGE INFORMATION

The Department of Labor requires all employees and spouses who are newly covered by the OCPS medical plan, dental and vision to receive this initial notice of COBRA rights. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact OCPS, or the designated COBRA Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### ***What is COBRA Continuation Coverage?***

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

#### ***When is COBRA Coverage Available?***

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after OCPS, or the designated COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify OCPS or the designated COBRA Administrator of the qualifying event.

#### ***You Must Give Notice of Some Qualifying Events***

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify OCPS or the designated COBRA Administrator within 60 days after the qualifying event occurs. You must provide this notice to: OCPS or the designated COBRA Administrator.

#### ***How is COBRA Coverage Provided?***

Once OCPS or the designated COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

***Disability extension of 18-month period of continuation coverage***

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify OCPS or the designated COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18month period of continuation coverage.

***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

***If You Have Questions***

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

***Keep Your Plan Informed of Address Changes***

In order to protect your family's rights, you should keep OCPS or the designated COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to OCPS or the designated COBRA Administrator.

**Plan Information**

OCPS Insurance Benefits  
445 W. Amelia Street, Orlando, FL 32801  
407.317.3245

**COBRA Information**

Total Administration Services Corporation (TASC)  
1350 Division Road Suite 301  
West Warwick, Rhode Island 02893  
1.800.720.4460

Please note domestic partners and their children are not considered eligible dependents for continuation of coverage through COBRA in accordance with IRS rules.

## **G. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

The Medical Indemnity Plan of the Orange County Public Schools (the “Plan”) will use protected health information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Notice of Privacy Practices for the Plan is found in Section H.

### ***PAYMENT FOR HEALTH CARE***

*Payment* includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, without limitation, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual’s claim).
2. Coordination of benefits.
3. Adjudication of health benefit claims (including appeals and other payment disputes).
4. Subrogation of health benefit claims.
5. Establishing employee contributions.
6. Adjusting amounts due based on enrollee health status and demographic characteristics.
7. Billing, collection activities and related health care data processing.
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments.
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).
10. Medical necessity reviews or appropriateness of care or justification of charges reviews.
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review.
12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name, address, date of birth, Social Security number, payment history, account number, name and address of the provider and/or health plan).
13. Reimbursement to the Plan.

## ***HEALTH CARE OPERATIONS***

*Health Care Operations* include, without limitation, the following activities:

1. Quality assessment.
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions.
3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities.
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance).
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies.
7. Business management and general administrative activities of the Plan, including, without limitation:
  - a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  - b. Customer service, including the provision of data analyses for policyholders, Plan sponsors or other customers.
8. Resolution of internal grievances.
9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity under HIPAA.

## ***THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFICIARY***

With an authorization, the Plan will disclose PHI to the Disability Insurance Plan or any other benefit plan of Orange County Public Schools that requires PHI as a prerequisite to obtain benefits for purposes related to administration of those plans.

***ORANGE COUNTY PUBLIC SCHOOLS IS THE PLAN SPONSOR***

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions and conditions outlined below.

***WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS***

The Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by HIPAA.
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual.
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual.
5. If it becomes aware, report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures as permitted by HIPAA.
6. Make PHI available to an individual in accordance with HIPAA's access requirements.
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.
8. If requested by an individual, make available the information required to provide an accounting of disclosures in accordance with HIPAA.
9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the United States Department of Health and Human Services' Secretary for the purpose of determining the Plan's compliance with HIPAA.
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction impracticable).

***ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR MUST BE MAINTAINED***

In accordance with HIPAA, only the following employees or classes of employees of Orange County Public Schools may be given access to PHI:

1. Sr. Director of Risk Management.
2. Staff designated by the Risk Manager.



## ***LIMITATIONS OF PHI ACCESS AND DISCLOSURE***

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

## ***NONCOMPLIANCE ISSUES***

If the persons described above do not comply with this policy, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

## **H. HEALTH INSURANCE “REQUIRED DISCLOSURES AND NOTICES”**

### ***NOTICE OF PRIVACY PRACTICES***

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS EFFECTIVE OCTOBER 1, 2008.**

If you have questions about this notice, please contact the Sr. Director, Risk Management at 407.317.3245.

### ***WHO WILL FOLLOW THIS NOTICE?***

This notice describes the medical information practices of the Medical Indemnity Plan of the Orange County Public Schools (the "Plan") and that of any third party that assists in the administration of Plan claims.

### ***OUR PLEDGE REGARDING MEDICAL INFORMATION***

The Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. The Plan creates a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records the Plan maintains. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which the Plan may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

The Plan is required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

### ***HOW THE PLAN MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU***

The following categories describe different ways that the Plan uses and discloses medical information. For each category of uses or disclosures the Plan will explain what the Plan means and present some examples. Not every use or disclosure in a category will be listed. All of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

***For Treatment (as described in applicable regulations)***

The Plan may use or disclose medical information about you to facilitate medical treatment or services by providers. The Plan may disclose medical information about you to providers including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

***For Payment (as described in applicable regulations)***

The Plan may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or precertification service provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

***For Health Care Operations (as described in applicable regulations).***

The Plan may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities, underwriting, premium rating, and other activities relating to Plan coverage, submitting claims for stop-loss (or excess loss) coverage, conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs, business planning and development such as cost management; and business management and general Plan administrative activities.

***As Required By Law***

The Plan will disclose medical information about you when required to do so by federal, state or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

***To Avert a Serious Threat to Health or Safety***

The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose medical information about you in a proceeding regarding the licensure of a physician.

***SPECIAL SITUATIONS***

***Disclosure to Health Plan Sponsor***

Information may be disclosed to another health plan maintained by the Plan Sponsor for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to the Plan Sponsor solely for purposes of administering benefits under the Plan.

***Organ and Tissue Donation***

If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

### ***Military and Veterans***

If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

### ***Workers' Compensation***

The Plan may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

### ***Public Health Risks***

The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

### ***Health Oversight Activities***

The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

### ***Lawsuits and Disputes***

If you are involved in a lawsuit or a dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

### ***Law Enforcement***

The Plan may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement;
- about a death the Plan believes may be the result of criminal conduct;
- about criminal conduct at the hospital, and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

### ***Coroners, Medical Examiners and Funeral Directors***

The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

### ***National Security and Intelligence Activities***

The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

### ***Inmates***

If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary:

- a. for the institution to provide you with health care;
- b. to protect your health and safety or the health and safety of others, or
- c. for the safety and security of the correctional institution.

## ***YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU***

You have the following rights regarding medical information the Plan maintains about you:

### ***Right to Inspect and Copy***

You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Sr. Director, Risk Management at 407.317.3245. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request.

The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

### ***Right to Amend***

If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Sr. Director, Risk Management. In addition, you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

### ***Right to an Accounting of Disclosures***

You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to the Sr. Director, Risk Management. Your request must state a time period which may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. **For additional lists**, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

### ***Right to Request Restrictions***

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

The Plan is not required to agree to your request.

To request restrictions, you must make your request in writing to the Sr. Director, Risk Management. In your request, you must tell us:

- a. what information you want to limit;
- b. whether you want to limit our use, disclosure or both; and
- c. to whom you want the limits to apply, for example, disclosures to your spouse.

### ***Right to Request Confidential Communications***

You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Sr. Director, Risk Management. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

### ***Right to Receive Notification of any Security Breaches***

If the Plan has any unsecured protected health information about you, and that unsecured information is accessed, acquired or disclosed by or to an unauthorized person, you have the right to receive notification about such security breach. The Plan will abide by breach notification requirements under the law.

### ***A Note About Personal Representatives***

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child. The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

### ***Right to a Paper Copy of This Notice***

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site, <http://Insurance.ocps.net>. To obtain a paper copy of this notice, contact the Sr. Director, Risk Management at 407.317.3245.

### ***Changes to This Notice***

The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for medical information the Plan already has about you as well as any information The Plan receives in the future. The Plan will post a copy of the current notice on the OCPS Intranet. The notice will contain on the first page, in the top right-hand corner, the effective date.

### ***Complaints***

If you believe your privacy rights have been violated you may file a complaint with the Plan. To file a complaint with the Plan, contact the Sr. Director, Risk Management at 407.317.3245. All complaints must be submitted in writing. In addition to filing a complaint with the Plan you may file a complaint with the Secretary of the Department of Health and Human Services.

Region IV, Office for Civil Rights, U.S. Department of Health and Human Services,  
Atlanta Federal Center,  
Suite 3B70, 61 Forsyth Street, SW.,  
Atlanta, GA 30303-8909.  
Voice Phone 404.562.7886 FAX 404.562.7881 TDD 404.331.2867

For all complaints filed by e-mail send to: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). You will not be penalized for filing a complaint.

### ***Other Uses of Medical Information***

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures the Plan has already made with your permission, and that the Plan is required to retain our records of the care that the Plan provided to you.

### ***INITIAL NOTICE REGARDING HIPAA'S SPECIAL ENROLLMENT PROVISION***

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

#### ***Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)***

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after 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](http://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 **1- 877-KIDS NOW** or [www.insurekidsnow.gov](http://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](http://www.askebsa.dol.gov) or call **1-866-444-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, 2019. Contact your State for more information on eligibility –**

<p align="center"><b>ALABAMA – Medicaid</b></p> <p>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447</p>	<p align="center"><b>FLORIDA – Medicaid</b></p> <p>Website: <a href="http://flmedicaidprecovery.com/hipp/">http://flmedicaidprecovery.com/hipp/</a> Phone: 1-877-357-3268</p>
<p align="center"><b>ALASKA – Medicaid</b></p> <p>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></p>	<p align="center"><b>GEORGIA – Medicaid</b></p> <p>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</p>
<p align="center"><b>ARKANSAS – Medicaid</b></p> <p>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p align="center"><b>INDIANA – Medicaid</b></p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864</p>
<p align="center"><b>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b></p> <p>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="http://Colorado.gov/HCPF/Child-Health-Plan-Plus">Colorado.gov/HCPF/Child-Health-Plan-Plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711</p>	<p align="center"><b>IOWA – Medicaid</b></p> <p>Website: <a href="http://dhs.iowa.gov/hawk-i">http://dhs.iowa.gov/hawk-i</a> Phone: 1-800-257-8563</p>
<p align="center"><b>KANSAS – Medicaid</b></p> <p>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> Phone: 1-785-296-3512</p>	<p align="center"><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/oi/hipp/htm">https://www.dhhs.nh.gov/oi/hipp/htm</a> Phone: 603-271-5218 1-800-852-3345, ext 5218</p>
<p align="center"><b>KENTUCKY – Medicaid</b></p> <p>Website: <a href="http://chfs.ky.gov">http://chfs.ky.gov</a> Phone: 1-800-635-2570</p>	<p align="center"><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710</p>
<p align="center"><b>LOUISIANA – Medicaid</b></p> <p>Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a> Phone: 1-888-695-2447</p>	<p align="center"><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831</p>



<p align="center"><b>MAINE – Medicaid</b></p> <p>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a>  Phone: 1-800-442-6003  TTY: Maine relay 711</p>	<p align="center"><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a>  Phone: 919-855-4100</p>
<p align="center"><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a>  Phone: 1-800-862-4840</p>	<p align="center"><b>NORTH DAKOTA – Medicaid</b></p> <p>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid">http://www.nd.gov/dhs/services/medicalserv/medicaid</a>  Phone: 1-844-854-4825</p>
<p align="center"><b>MINNESOTA – Medicaid</b></p> <p>Website: <a href="http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp">http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp</a>  Phone: 1-800-657-3739</p>	<p align="center"><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>
<p align="center"><b>MISSOURI – Medicaid</b></p> <p>Website: <a href="https://www.dss.mo.gov/mhd/participants/pages/hipp.htm">https://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>	<p align="center"><b>OREGON – Medicaid</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>  <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a>  Phone: 1-800-699-9075</p>
<p align="center"><b>MONTANA – Medicaid</b></p> <p>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>  Phone: 1-800-694-3084</p>	<p align="center"><b>PENNSYLVANIA – Medicaid</b></p> <p>Website: <a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a>  Phone: 1-800-692-7462</p>
<p align="center"><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>  Phone: (855) 632-7633  Lincoln: (402) 473-7000  Omaha: (402) 595-1178</p>	<p align="center"><b>RHODE ISLAND – Medicaid</b></p> <p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>  Phone: 855-697-4347</p>
<p align="center"><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="https://dhcfp.nv.gov">https://dhcfp.nv.gov</a>  Medicaid Phone: 1-800-992-0900</p>	<p align="center"><b>SOUTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>

<b>SOUTH DAKOTA - Medicaid</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a> Phone: 1-800-562-3022 ext. 15473
<b>TEXAS – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493	Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>UTAH – Medicaid and CHIP</b>	<b>WISCONSIN – Medicaid and CHIP</b>
Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669	Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a> Phone: 1-800-362-3002
<b>VERMONT– Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427	Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a> Phone: 307-777-7531
<b>VIRGINIA – Medicaid and CHIP</b>	
Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a> Medicaid Phone: 1-800-432-5924 CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a> CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

### ***NEWBORNS AND MOTHERS HEALTH PROTECTION ACT***

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

### ***WOMAN’S HEALTH AND CANCER RIGHTS***

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

- Reconstruction of the breast upon which the mastectomy has been performed,

- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymphedemas

In addition, the plan may not:

- interfere with a woman's rights under the plan to avoid these requirements, or
- offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

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

### ***QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)***

#### ***Eligibility for Coverage under a QMCSO***

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

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

#### ***Qualified Medical Child Support Order Defined***

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

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

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

#### ***Payment of Benefits***

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

## ***COVERAGE OF STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE (MICHELLE'S LAW)***

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

Coverage will terminate on the earlier of:

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

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

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

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

## ***NOTICE OF FEDERAL REQUIREMENTS UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)***

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical, 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 Healthcare 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, 2018-2019 plan years and is being renewed for the subsequent

2019-2020 plan year beginning October 1, 2019 and ending September 30, 2020. The election may be renewed for subsequent plan years.

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

### ***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 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/](https://www.ocps.net/departments/risk_management/insurance_benefits/).

## I. PLAN ADMINISTRATION

Name of Plan:

The Medical Indemnity Plan of the Orange County Public Schools  
Employer whose employees are covered by the Plan (the "Employer"):  
The School Board of Orange County, Florida

Policy Number: 08001 I.R.S. Employer Identification No. of sponsor of the Plan: 59-6000771

Plan number assigned by sponsor of the Plan: 502

Plan Administrator:

Orange County Public Schools, Senior Director, Risk Management  
445 W. Amelia St.  
Orlando, FL 32801  
407.317.3245

Name and address of agent for service of legal process:

Dr. Barbara Jenkins, Superintendent  
Orange County Public Schools  
P. O. Box 271, Orlando, FL 32802

(Service of legal process may also be made upon the plan administrator).

The general administration of this plan is provided by the third party administrator contracted to handle certain administrative responsibilities and to process claims:

Cigna Health Plans	CVS/Caremark
Hamilton Village Claim Office	One CVS Drive
P.O. Box 182223	Woonsocket, RI 027895
Chattanooga, TN 37422-7223	1.800.378.9264
1.800.244.6224	

Covered employees contribute toward the cost of coverage through payroll deductions or salary reduction through the Section 125 plan. All other contributions are provided by the employer. All benefits are funded through the School Board of Orange County, Florida, Employee Benefits Trust with the majority of assets held at Wells Fargo of Orlando. Investment instruments may be made through other institutions as appropriate. Name and title for the Trustees of the Trust are as follows:

Dr. Barbara Jenkins, Superintendent  
Orange County Public Schools

Richard Collins, Consultant  
Orange County Public Schools

Dr. Karen van Caulil, President  
Florida Health Care Coalition

Dale Kelly, Chief Financial Officer  
Orange County Public Schools

Meredith Robertson, Consultant  
University of Central Florida

Trustees can be reached at Orange County Public Schools, P.O. Box 271, Orlando, FL 32802.