



# Open Enrollment 2016

## Summary Kit

# *Medical*

## CareFirst

### HealthyBlue Open Access HMO Option B



# HealthyBlue HMO

## *Non-Integrated Deductible*

### Summary of Benefits

Services	In-Network You Pay <sup>1</sup>
Visit <a href="http://www.carefirst.com/findadoc">www.carefirst.com/findadoc</a> to locate providers	
<b>24/7 FIRSTHELP™ NURSE ADVICE LINE</b>	
Free advice from a registered nurse	When your doctor is not available, call FirstHelp™ to speak with a registered nurse about your health questions and treatment options. Call (800) 535-9700.
<b>BLUE REWARDS</b>	
Visit <a href="http://www.carefirst.com/bluerewards">www.carefirst.com/bluerewards</a> for more information	Blue Rewards is an incentive program where you can earn up to \$600 per adult and \$1,500 per family for taking an active role in getting healthy and staying healthy.
<b>ANNUAL DEDUCTIBLE (Benefit period)<sup>2</sup></b>	
Individual	\$500
Family	\$1,000
<b>ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)<sup>3</sup></b>	
Medical <sup>4</sup>	\$4,500 Individual/\$6,550 Family
Prescription Drug <sup>4</sup>	Combined in-network medical out-of-pocket maximum
<b>LIFETIME MAXIMUM BENEFIT</b>	
Lifetime Maximum	None
<b>PREVENTIVE SERVICES</b>	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
<b>OFFICE VISITS, LABS AND TESTING</b>	
Facility Charge: In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge	\$50 per visit
Office Visits for Illness <sup>5</sup>	No charge* PCP/\$30 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans) <sup>5,6</sup>	No charge*
Lab <sup>5,6</sup>	No charge*
X-ray <sup>5,6</sup>	No charge*
Allergy Testing <sup>5</sup>	No charge* PCP/\$30 Specialist per visit
Allergy Shots <sup>5</sup>	No charge* PCP/\$30 Specialist per visit
Physical, Speech and Occupational Therapy <sup>5,7</sup> (limited to 30 visits/injury/benefit period)	\$30 per visit
Chiropractic <sup>5</sup> (limited to 20 visits/benefit period)	\$30 per visit
Acupuncture <sup>5</sup>	\$30 per visit
<b>EMERGENCY SERVICES</b>	
Urgent Care Center	\$50 per visit
Emergency Room—Facility Services	\$200 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*
Ambulance (if medically necessary)	\$50 per service

Services	In-Network You Pay <sup>1</sup>
<b>HOSPITALIZATION</b> <b>(Members are responsible for applicable physician and facility fees)</b>	
Outpatient Facility Surgery (Freestanding Facility)	
Outpatient Facility Surgery (Freestanding Facility)	\$100 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then \$300 per visit
Outpatient Physician Services	No charge* after deductible
Inpatient Facility Services	Deductible, then \$300 per admission
Inpatient Physician Services	No charge* after deductible
<b>HOSPITAL ALTERNATIVES</b>	
Home Health Care	Deductible, then \$30 per visit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	Inpatient-Deductible, then \$30 per admission Outpatient-Deductible, then \$30 per visit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then \$30 per admission
<b>MATERNITY</b>	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	Deductible, then \$300 per admission
Nursery Care of Newborn	No charge* after deductible
Artificial and Intrauterine Insemination <sup>8</sup>	Not covered
In Vitro Fertilization Procedures <sup>8</sup>	Not covered
<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b> <b>(Members are responsible for applicable physician and facility fees)</b>	
Inpatient Facility Services	Deductible, then \$300 per admission
Inpatient Physician Services	No charge* after deductible
Outpatient Facility Services	No charge*
Outpatient Physician Services	No charge*
Office Visits	No charge*
Medication Management	No charge*
<b>MEDICAL DEVICES AND SUPPLIES</b>	
Durable Medical Equipment	No charge* after deductible
Hearing Aids	Not covered
<b>VISION</b>	
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit at participating Vision Provider
Eyeglasses and Contact Lenses	Discounts from participating Vision Provider

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges \$100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept \$50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to \$50.

- \* No copayment or coinsurance.
- <sup>1</sup> When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
- <sup>2</sup> For family coverage only: The family deductible must be met before any member starts receiving benefits as indicated above. The deductible may be met by one member or any combination of members..
- <sup>3</sup> For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.
- <sup>4</sup> Plan has an integrated medical and prescription drug out-of-pocket maximum.
- <sup>5</sup> If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
- <sup>6</sup> Members who reside in the CareFirst service area must use LabCorp as their Lab Test facility and freestanding facilities for Imaging and X-rays.
- <sup>7</sup> There are no limits for children under age 21 when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.
- <sup>8</sup> Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Provider (PCP). To select a PCP, go to [www.carefirst.com](http://www.carefirst.com) for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: DC/CFBC/GC (R. 1/13); DC/CFBC/DOL APPEAL (R. 7/11); DC/CFBC/ATTC (R. 1/10); DC/CFBC/HB HMO EOC (1/13); DC/CFBC/HB HMO DOCS (1/13); DC/CFBC/HB HMO SOB (1/13); DC/CFBC/LG/ADV/INCENT (1/15); DC/CFBC/RX3 (R. 1/15) and any amendments.



CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association, providing access to the Preferred Provider Organization Network only and does not assume any financial risk or obligation with respect to claims. ®Registered trademark of the Blue Cross and Blue Shield Association. ®Registered trademark of CareFirst of Maryland, Inc.

# Pharmacy Program

\$100 Deductible ■ \$0/15/35/60 Retail Copays  
50% Injectables Coinsurance

## Summary of Benefits

Plan Feature	Amount	Description
<b>Individual Deductible</b>	\$100	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any deductible are noted below.
<b>Family Deductible</b>	\$200	If your family has met the deductible, all members will pay the copays associated with the drugs prescribed. No one family member may contribute more than the individual deductible amount to the family deductible.
<b>Preventive Drugs (Affordable Care Act) (up to a 34-day supply)</b>	\$0 (Not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List (ACA).* (Examples: Folic Acid, Fluoride and FDA approved contraceptives for women.)
<b>Oral Chemotherapy Drugs Diabetic Supplies (up to a 34-day supply)</b>	\$0 (not subject to deductible except for HSA Plans)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
<b>Generic Drugs – (Tier 1) (up to a 34-day supply)</b>	\$15	Generic drugs are covered at this copay level.
<b>Preferred Brand Drugs (Tier 2) (up to a 34-day supply)</b>	\$35	All preferred brand drugs are covered at this copay level.
<b>Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)</b>	\$60	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
<b>Self-administered Injectable (excluding insulin) (Tier 4) (up to a 34-day supply)</b>	50% coinsurance up to a maximum payment of \$100	All self-administered injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
<b>Maintenance Drugs (up to a 90-day supply)</b>	Generic: \$30 Preferred Brand: \$70 Non-preferred Brand: \$120 Self-Administered Injectables: 50% coinsurance, up to a maximum payment of \$200	Maintenance drugs of up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Injectables (excluding insulin) are covered at 50% coinsurance up to a maximum payment of \$200.
<b>Restricted Generic Substitution</b>	Yes	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay.



\*Access the drug search tool at [www.carefirst.com/rx](http://www.carefirst.com/rx) for the most up-to-date Preferred Drug List, Preventive Drug List (ACA) and care management criteria. Care management criteria are applied so that some medications can be used in limited quantities; others require that your doctor obtain prior authorization from CareFirst before they can be filled.

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

**Policy Form Numbers:** DC/CFBC/RX3 (R. 8/12) • DC/CF/RX3 (R. 8/12)



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# BlueVision

## *A plan for healthy eyes, healthy lives*

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

### How the plan works

#### How do I find a provider?

To find a provider, go to [www.carefirst.com](http://www.carefirst.com) and utilize the *Find a Provider* feature or call Davis Vision at **(800) 783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

#### How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

#### Can I get contacts and eyeglasses in the same benefit period?

With BlueVision, you receive one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price.<sup>1</sup>

#### Mail order replacement contact lenses

**DavisVisionContacts.com** offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.



Need more information?

Please visit

[www.carefirst.com](http://www.carefirst.com) or  
call **(800) 783-5602**.

<sup>1</sup>As of 4/1/14, some providers in Maryland may no longer provide these discounts.



BlueVision

A plan for healthy eyes, healthy lives

## Summary of Benefits (12-month benefit period)

In-Network	You Pay
<b>EYE EXAMINATIONS<sup>1</sup></b>	
Routine Eye Examination with dilation (per benefit period)	\$10
<b>FRAMES<sup>1,2</sup></b>	
Priced up to \$70 retail	\$40
Priced above \$70 retail	\$40, plus 90% of the amount over \$70
<b>SPECTACLE LENSES<sup>2</sup></b>	
Single Vision	\$35
Bifocal	\$55
Trifocal	\$65
Lenticular	\$110
<b>LENS OPTIONS<sup>2,3</sup> (add to spectacle lens prices above)</b>	
Standard Progressive Lenses	\$75
Premium Progressive Lenses (Varilux®, etc.)	\$125
Ultra Progressive Lenses (digital)	\$140
Polarized Lenses	\$75
High Index Lenses	\$55
Glass Lenses	\$18
Polycarbonate Lenses	\$30
Blended Invisible Bifocals	\$20
Intermediate Vision Lenses	\$30
Photochromic Lenses	\$35
Scratch-Resistant Coating	\$20
Standard Anti-Reflective Coating	\$45
Ultraviolet (UV) Coating	\$15
Solid Tint	\$10
Gradient Tint	\$12
Plastic Photosensitive Lenses	\$65

In-Network	You Pay
<b>CONTACT LENSES<sup>1,2</sup></b>	
Contact Lens Evaluation and Fitting	85% of retail price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
<b>LASER VISION CORRECTION<sup>2</sup></b>	
	Up to 25% off allowed amount or 5% off any advertised special <sup>4</sup>

<sup>1</sup> At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.

<sup>2</sup> CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland may no longer provide these discounts.

<sup>3</sup> Special lens designs, materials, powers and frames may require additional cost.

<sup>4</sup> Some providers have flat fees that are equivalent to these discounts.

### Exclusions

The following services are excluded from coverage:

- Diagnostic services, except as listed in *What's Covered* under the Evidence of Coverage.
- Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
- Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
- Services or supplies not specifically approved by the Vision Care Designee where required in *What's Covered* under the Evidence of Coverage.
- Orthoptics, vision training and low vision aids.
- Glasses, sunglasses or contact lenses.
- Vision Care services for cosmetic use.
- Services obtained from Non-Contracting Providers.

For BlueChoice Opt-Out Plus members, Vision Care benefits are not available under the Out-of-Network Evidence of Coverage.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts may still apply.

Benefits issued under policy form numbers: MD/BC-OOP/VISION (R. 6/04) • DC/BC-OOP/VISION (R. 6/04) • VA/BC-OOP/VISION (R. 6/04)



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***Medical***  
CareFirst  
HealthyBlue Advantage  
Option B



# HealthyBlue Advantage

## *Non-Integrated Deductible*

### Summary of Benefits

Services	In-Network You Pay <sup>1,2</sup>	Out-of-Network You Pay <sup>1,3</sup>
Visit <a href="http://www.carefirst.com/findadoc">www.carefirst.com/findadoc</a> to locate providers		
<b>24/7 FIRSTHELP™ NURSE ADVICE LINE</b>		
Free advice from a registered nurse	When your doctor is not available, call FirstHelp™ to speak with a registered nurse about your health questions and treatment options. Call (800) 535-9700.	
<b>BLUE REWARDS</b>		
Visit <a href="http://www.carefirst.com/bluerewards">www.carefirst.com/bluerewards</a> for more information	Blue Rewards is an incentive program where you can earn up to \$600 per adult and \$1,500 per family for taking an active role in getting healthy and staying healthy.	
<b>ANNUAL DEDUCTIBLE (Benefit period)<sup>4</sup></b>		
Individual	\$500	\$1,500
Family	\$1,000	\$3,000
<b>ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)<sup>5</sup></b>		
Medical <sup>6</sup>	\$4,500 Individual/\$6,550 Family	\$6,000 Individual/\$12,000 Family
Prescription Drug <sup>6</sup>	Combined with in-network medical out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
<b>LIFETIME MAXIMUM BENEFIT</b>		
Lifetime Maximum	None	None
<b>PREVENTIVE SERVICES</b>		
Well-Child Care (including exams & immunizations)	No charge*	No charge* after deductible
Adult Physical Examination (including routine GYN visit)	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	\$50 per visit
Pap Test	No charge*	\$50 per visit
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
<b>OFFICE VISITS, LABS AND TESTING</b>		
Office Visits for Illness	No charge* PCP/\$30 Specialist per visit	Deductible, then \$50 per visit
Imaging (MRA/MRS, MRI, PET & CAT scans) <sup>7</sup>	No charge*	Deductible, then \$50 per visit
Lab <sup>7</sup>	No charge*	Deductible, then \$50 per visit
X-ray <sup>7</sup>	No charge*	Deductible, then \$50 per visit
Allergy Testing	No charge* PCP/\$30 Specialist per visit	Deductible, then \$50 per visit
Allergy Shots	No charge* PCP/\$30 Specialist per visit	Deductible, then \$50 per visit
Physical, Speech and Occupational Therapy <sup>8</sup> (limited to 30 visits/injury/benefit period)	\$30 per visit	Deductible, then \$50 per visit
Chiropractic (limited to 20 visits/benefit period)	\$30 per visit	Deductible, then \$50 per visit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
<b>EMERGENCY SERVICES</b>		
Urgent Care Center	\$50 per visit	\$50 per visit
Emergency Room—Facility Services	\$200 per visit (waived if admitted)	\$200 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*	No charge*
Ambulance (if medically necessary)	\$50 per service	\$50 per service

Services	In-Network You Pay <sup>1,2</sup>	Out-of-Network You Pay <sup>1,3</sup>
<b>HOSPITALIZATION</b> <b>(Members are responsible for applicable physician and facility fees)</b>		
Outpatient Facility Surgery (Freestanding Facility)		
Outpatient Facility Surgery (Freestanding Facility)	\$100 per visit	Deductible, then \$500 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then \$300 per visit	Deductible, then \$500 per visit
Outpatient Physician Services	No charge* after deductible	Deductible, then \$50 per visit
Inpatient Facility Services	Deductible, then \$300 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then \$50 per visit
<b>HOSPITAL ALTERNATIVES</b>		
Home Health Care		
Home Health Care	Deductible, then \$30 per visit	Deductible, then \$50 per visit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	Deductible, then \$30 per admission	Deductible, then \$50 per admission
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then \$30 per admission	Deductible, then \$50 per admission
<b>MATERNITY</b>		
Preventive Prenatal and Postnatal Office Visits		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then \$50 per visit
Delivery and Facility Services	Deductible, then \$300 per admission	Deductible, then \$500 per admission
Nursery Care of Newborn	No charge* after deductible	Deductible, then \$50 per visit
Artificial and Intrauterine Insemination <sup>9</sup>	Not covered	Not covered
In Vitro Fertilization Procedures <sup>9</sup>	Not covered	Not covered
<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b> <b>(Members are responsible for applicable physician and facility fees)</b>		
Inpatient Facility Services		
Inpatient Facility Services	Deductible, then \$300 per admission	Deductible, then \$500 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then \$50 per visit
Outpatient Facility Services	No charge*	Deductible, then \$30 per visit
Outpatient Physician Services	No charge*	Deductible, then \$50 per visit
Office Visits	No charge*	Deductible, then \$30 per visit
Medication Management	No charge*	Deductible, then \$50 per visit
<b>MEDICAL DEVICES AND SUPPLIES</b>		
Durable Medical Equipment		
Durable Medical Equipment	Deductible, then \$30 per visit	Deductible, then \$50 per visit
Hearing Aids	Not covered	Not covered
<b>VISION</b>		
Routine Exam (limited to 1 visit/benefit period)		
Routine Exam (limited to 1 visit/benefit period)	\$10 per visit at participating Vision Provider	Plan pays \$33, member pays balance
Eyeglasses and Contact Lenses	Discounts from participating Vision Provider	Not covered

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges \$100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept \$50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to \$50.

- \* No copayment or coinsurance.
- <sup>1</sup> When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
- <sup>2</sup> In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.
- <sup>3</sup> Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.
- <sup>4</sup> For family coverage only: The family deductible must be met before any member starts receiving benefits as indicated above. The deductible may be met by one member or any combination of members..
- <sup>5</sup> For family coverage only: The family out-of-pocket maximum must be met before any member's services will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum may be met by one member or any combination of members.
- <sup>6</sup> Plan has an integrated medical and prescription drug out-of-pocket maximum.
- <sup>7</sup> If you receive laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) members should use LabCorp to receive In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered out-of-network. If you receive laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO laboratory and receive in-network benefits.
- <sup>8</sup> There are no limits for children under age 21 when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.
- <sup>9</sup> Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

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# Pharmacy Program

**\$100 Deductible ■ \$0/15/35/60 Retail Copays  
50% Injectables Coinsurance**

## Summary of Benefits

Plan Feature	Amount	Description
<b>Individual Deductible</b>	\$100	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any deductible are noted below.
<b>Family Deductible</b>	\$200	If your family has met the deductible, all members will pay the copays associated with the drugs prescribed. No one family member may contribute more than the individual deductible amount to the family deductible.
<b>Preventive Drugs (Affordable Care Act) (up to a 34-day supply)</b>	\$0 (Not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List (ACA).* (Examples: Folic Acid, Fluoride and FDA approved contraceptives for women.)
<b>Oral Chemotherapy Drugs Diabetic Supplies (up to a 34-day supply)</b>	\$0 (not subject to deductible except for HSA Plans)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
<b>Generic Drugs – (Tier 1) (up to a 34-day supply)</b>	\$15	Generic drugs are covered at this copay level.
<b>Preferred Brand Drugs (Tier 2) (up to a 34-day supply)</b>	\$35	All preferred brand drugs are covered at this copay level.
<b>Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)</b>	\$60	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
<b>Self-administered Injectable (excluding insulin) (Tier 4) (up to a 34-day supply)</b>	50% coinsurance up to a maximum payment of \$100	All self-administered injectable drugs (excluding insulin) are covered at this payment level. Insulin is covered at appropriate copay level.
<b>Maintenance Drugs (up to a 90-day supply)</b>	Generic: \$30 Preferred Brand: \$70 Non-preferred Brand: \$120 Self-Administered Injectables: 50% coinsurance, up to a maximum payment of \$200	Maintenance drugs of up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Injectables (excluding insulin) are covered at 50% coinsurance up to a maximum payment of \$200.
<b>Restricted Generic Substitution</b>	Yes	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay.



\*Access the drug search tool at [www.carefirst.com/rx](http://www.carefirst.com/rx) for the most up-to-date Preferred Drug List, Preventive Drug List (ACA) and care management criteria. Care management criteria are applied so that some medications can be used in limited quantities; others require that your doctor obtain prior authorization from CareFirst before they can be filled.

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

**Policy Form Numbers:** DC/CFBC/RX3 (R. 8/12) • DC/CF/RX3 (R. 8/12)



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# BlueVision

## *A plan for healthy eyes, healthy lives*

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

### How the plan works

#### How do I find a provider?

To find a provider, go to [www.carefirst.com](http://www.carefirst.com) and utilize the *Find a Provider* feature or call Davis Vision at **(800) 783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

#### How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

#### What if I go out-of-network?

BlueVision offers an allowance for a routine eye exam, eyeglasses, and contact lenses at a non-Davis Vision provider. You will be responsible for paying the entire amount of the service fees up-front. Out-of-network benefits are limited to an allowed benefit. After the services, you can submit your claim to Davis Vision for reimbursement. You can find the claim form by going to [www.carefirst.com](http://www.carefirst.com), locate *For Members*, then click on *Forms, Vision, Davis Vision*.

#### Can I get contacts and eyeglasses in the same benefit period?

With BlueVision, you receive one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price.<sup>1</sup>

#### Mail order replacement contact lenses

**DavisVisionContacts.com** offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.



Need more information?

Please visit

[www.carefirst.com](http://www.carefirst.com) or  
call **(800) 783-5602**.

<sup>1</sup>As of 4/1/14, some providers in Maryland may no longer provide these discounts.



BlueVision

A plan for healthy eyes, healthy lives

## Summary of Benefits (12-month benefit period)

In-Network	You Pay
<b>EYE EXAMINATIONS<sup>1</sup></b>	
Routine Eye Examination with dilation (per benefit period)	\$10
<b>FRAMES<sup>1,2</sup></b>	
Priced up to \$70 retail	\$40
Priced above \$70 retail	\$40, plus 90% of the amount over \$70
<b>SPECTACLE LENSES<sup>2</sup></b>	
Single Vision	\$35
Bifocal	\$55
Trifocal	\$65
Lenticular	\$110
<b>LENS OPTIONS<sup>2,3</sup> (add to spectacle lens prices above)</b>	
Standard Progressive Lenses	\$75
Premium Progressive Lenses (Varilux®, etc.)	\$125
Ultra Progressive Lenses (digital)	\$140
Polarized Lenses	\$75
High Index Lenses	\$55
Glass Lenses	\$18
Polycarbonate Lenses	\$30
Blended Invisible Bifocals	\$20
Intermediate Vision Lenses	\$30
Photochromic Lenses	\$35
Scratch-Resistant Coating	\$20
Standard Anti-Reflective Coating	\$45
Ultraviolet (UV) Coating	\$15
Solid Tint	\$10
Gradient Tint	\$12
Plastic Photosensitive Lenses	\$65
<b>CONTACT LENSES<sup>1,2</sup></b>	
Contact Lens Evaluation and Fitting	85% of Retail Price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
<b>LASER VISION CORRECTION<sup>2</sup></b>	
	Up to 25% off allowed amount or 5% off any advertised special <sup>4</sup>

Out-of-Network	You Pay
Routine Eye Examination with dilation (per benefit period)	Plan pays \$33, you pay balance
Frames <sup>2</sup>	Plan pays \$15, you pay balance
Single Lenses <sup>2</sup>	Plan pays \$20, you pay balance
Bifocal Lenses <sup>2</sup>	Plan pays \$35, you pay balance
Trifocal Lenses <sup>2</sup>	Plan pays \$45, you pay balance
Medically Necessary Contacts <sup>2</sup>	Plan pays \$80, you pay balance
Routine Contacts <sup>2</sup>	Plan pays \$10, you pay balance
Bifocal Contacts <sup>2</sup>	90% of Retail Price

<sup>1</sup> At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.

<sup>2</sup> CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland may no longer provide these discounts.

<sup>3</sup> Special lens designs, materials, powers and frames may require additional cost.

<sup>4</sup> Some providers have flat fees that are equivalent to these discounts.

### Exclusions

The following services are excluded from coverage:

- Diagnostic services, except as listed in *What's Covered* under the Evidence of Coverage.
- Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
- Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
- Services or supplies not specifically approved by the Vision Care Designee where required in *What's Covered* under the Evidence of Coverage.
- Orthoptics, vision training and low vision aids.
- Glasses, sunglasses or contact lenses.
- Vision Care services for cosmetic use.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts may still apply.

Benefits issued under policy form numbers: MD/BCOO/VISION (R. 1/06)  
• DC/BCOO/VISION (R. 1/06) • VA/BCOO/VISION (R. 1/06).



The CareFirst BlueCross BlueShield  
family of health care plans

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**CareFirst**  
Blue Rewards  
&  
Vaccine Program



# Blue Rewards Means Money Back

*Start Earning Your Reward Today*

Taking steps to get and stay healthy has its rewards. Complete 4 steps within 120 days of your effective date to earn your Blue Reward. You can use your reward to pay for eligible expenses related to your health plan.

## Blue Rewards



Welcome Amy Smith Employer Name [Switch](#)

**Medical Plan Summary**

Plan Type: BluePreferred PPO	Group Number: XXXX	<a href="#">View All Plans &gt;</a>
Metal Level: Gold	Member ID: 123456789	<a href="#">Pay My Bill</a>
Start Date: December 1, 2013	Subscriber Name: Amy Smith	<a href="#">Covered Members</a>
PCP: John Jones M.D.	Email : Amy@gmail.com	<a href="#">ID Cards</a>
PCP Copay: \$15	Specialist Copay: \$35	<a href="#">Change</a>

Deductible  
**In Network** Remaining: \$700.00      **Out of Pocket**  [More >](#)  
Met \$300.00 Out of \$1000.00

In Network Remaining: \$900.00      Met \$600.00 Out of \$1500.00      [More >](#)

[Log Out](#) | [Text Size: A A A](#)

**Quick Links**

- [Blue Rewards](#)
- [EOBs](#)
- [My Claims](#)
- [Select/Change PCP](#)
- [Drug Pricing Tool](#)
- [Treatment Cost Estimator](#)

**BlueRewards means money back!**

**Start Earning Now**

## Get Started with Blue Rewards

It's easy to begin earning and tracking your Blue Reward.

- Register or log in to [My Account](#), our secure member website, at [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount)
- Click on *Blue Rewards* under *Quick Links*, or
- Click on the *Start Earning Now* button

## Blue Rewards

Get rewarded for making healthy choices.

Earn up to \$750 per family!

- Earn up to \$300 per adult, up to \$75 per child.
- Earn a CareFirst Blue Rewards Visa® Incentive Card.

- [Learn about Blue Rewards](#)
- [Health and Wellness Evaluation Form](#)
- [How to use your incentive card](#)
- [Blue Rewards Resources](#)



Member	Last day to submit	Select a PCMH PCP	E-consent	Health Assessment	Health and Wellness Evaluation	
Amy (06/19/1964)	04/01/2015	<a href="#">Start</a>	<a href="#">Start</a>	<a href="#">Start</a>	<a href="#">Start</a>	<a href="#">View Details &gt;</a>
John * (06/19/1964)	04/01/2015	Start	Start	Start	Start	<a href="#">View Details &gt;</a>
Bobby (06/19/1999)	04/01/2015	Start	N/A	N/A	<a href="#">Start</a>	<a href="#">View Details &gt;</a>
Suzanne	04/01/2015	Start	N/A	N/A	<a href="#">Start</a>	<a href="#">View Details &gt;</a>

# 1

### Select a Patient-Centered Medical Home (PCMH) PCP:

To search for a PCMH doctor, simply click on the check box and look for the PCMH symbol.



Note: If you have a PPO or Advantage plan, and you are outside of the CareFirst service area (Maryland, D.C. or Northern Virginia) you can select a provider in the BlueCard® PPO network who specializes in General Practice, Family Practice, Internal Medicine, Pediatrics or Geriatrics.

## 4 Steps to Earn your Blue Reward

Click on Start to begin each step of the Blue Rewards process. Once you complete step 1, the rest of the steps can be completed in any order.

- **Step 1:** Select a Patient-Centered Medical Home primary care provider (PCP) (Ages 2+)
- **Step 2:** Consent to Electronic Communications (Ages 18+)
- **Step 3:** Complete the Online Health Assessment (Ages 18+)
- **Step 4:** Complete your Health and Wellness Evaluation (Ages 2+)

The policyholder can visit the Blue Rewards homepage at any time to see which steps have been completed by each family member.


Log Out

[Home](#) [My Coverage](#) [Claims](#) [Doctors](#) [My Health](#) [Plan Documents](#) [Tools](#) [Help](#)

### Select/Change PCP

Medical

**How to select/Change your Primary Care Provider (PCP)**

- Search the Directory for your new PCP or Existing PCP,
- Click the "Select this Provider as my PCP" link in the provider's listing and complete the PCP form.

**Provider Type**

**Primary Care Provider (PCP)**

**What PCP**

**My Group Name**

Show only providers who accept new patients  
 Show only practitioners in CareFirst's Patient-Centered Medical Home Program

**2**

## Consent to Electronic Communications:

Simply check Yes and click *Submit* to start receiving wellness-related communications on your computer, tablet or smartphone.

CareFirst BlueCross BlueShield (CareFirst) wants to help you manage your health care information and simplify your life with electronic communications. Instead of paper, you can receive emails and/or text messages regarding your health care coverage by providing your email address and/or phone number. By checking this box, you are giving CareFirst permission to communicate with you electronically. If you do not check this box, you will receive paper notices. In addition, CareFirst will notify you about Explanation of Benefits, Health and Wellness news and other correspondence delivered electronically.

Yes, I agree  
 No, I do not agree

**Submit** **Cancel**

**3**

## Complete the Health Assessment:

Select Yes to consent to share the information with your PCMH PCP, then click the *Continue* button to be taken to the online survey.

Answer a variety of health and lifestyle questions that will help you get an accurate picture of your health status.

**Health Assessment Consent**

I authorize CareFirst to release my health assessment questionnaire including my responses to the questions contained therein to my designated primary care provider (PCP). I understand that my personal health information may be disclosed as required by or allowed by law.

If you do not give consent you will not be eligible for your Blue Reward. It may take up to 24 hours before your health assessment is reflected in My Account. Please make sure your pop blocker is turned off before you continue.

Yes  
 No

**Continue**

# 4

## Complete your Health and Wellness Evaluation Form:

- Print the Health and Wellness Evaluation Form available at [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount)
- Call your selected PCMH PCP and schedule the necessary lab work needed to complete your evaluation (including blood glucose)
- Visit your doctor to complete and sign the form
- Enter your results online and keep your form for your records

**CareFirst**

Home My Coverage Claims Doctors My Health Plan Documents Tools Help

Home / Blue Rewards / Amy (06/23/1988) / Instructions / Form Step1 / Form Step2

Health and Wellness Evaluation Form

Step 1 Participant & Provider Information Step 2 Health Measures Step 3 Screening/Immunization

Section III: Health Measures

1. Weight  Waiver Provided by PCP

Date Measured:  MM/YYYY  Adult BMI

Adult Height: (optional)  in  Adult Weight: (optional)  lbs  Adult Waist Measurement: (optional)  in

Alternative Standard Set at initial screening

2. Flu Vaccine  Waiver Provided by PCP

**CareFirst**

Home My Coverage Claims Doctors My Health Plan Documents Tools Help

Home / Blue Rewards / Amy (06/23/1988)

Blue Rewards Details for Amy (06/23/1988) **BlueRewards**

Congratulations! You have earned your Blue Reward.

Blue Rewards Earned		Health and Wellness Evaluation Form Results	
\$300	Rewards Earned out of \$300	Date Earned: 01/10/2014	Weight: BMI 25 Flu Vaccine: Yes
		Reward Type: CareFirst Blue Rewards Visa® Incentive Card	Tobacco use: Yes Blood Pressure: 100/80
		Blood Glucose: 110 Cholesterol: 180mg/dl	Screenings/ Immunization: Yes <a href="#">View Details</a>

Want to check your card balance?

Policyholders can check the balance and transaction history of their Blue Rewards by clicking [View Payments](#) from the landing page and then [View Balances and Transactions](#).

**Congratulations!**  
You have earned your  
Blue Reward

Your reward can be used for out-of-pocket costs like copays or coinsurance related to your CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. health plan (including medical, prescription drug, dental and vision expenses).

You can use your CareFirst Blue Rewards Visa® Incentive Card at doctors' offices, pharmacies, dental offices, vision care centers, urgent care centers and hospitals.

The card can be used during the benefit period in which you earned the incentive and will expire the last day of your benefit period.

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The CareFirst Blue Rewards Visa Incentive Card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The card may not be used everywhere Visa debit cards are accepted. No cash access permitted. The Bancorp Bank; Member FDIC.

*Dental*  
Dominion  
Access ePPO/PPO



## Choice 100/80/50/50

	In Network	Out of Network
<b>DIAGNOSTIC &amp; PREVENTIVE</b>		
Oral examinations	100%	100%
Teeth cleaning	100%	100%
X-rays	100%	100%
<b>BASIC RESTORATIVE</b>		
Fillings	80%	80%
Simple extractions	80%	80%
Denture repairs	80%	80%
General anesthesia	80%	80%
<b>ENDODONTICS</b>		
Root canals	50%	50%
<b>PERIODONTICS</b>		
Scaling and root planing	50%	50%
Gingivectomy/gingivoplasty	50%	50%
<b>ORAL SURGERY</b>		
Extraction of impacted teeth	50%	50%
<b>MAJOR RESTORATIVE</b>		
Inlays and onlays	50%	50%
Crowns	50%	50%
Dentures	50%	50%
Implants (in lieu of a 3-unit bridge)	50%	50%
Fixed bridges	50%	50%
<b>ORTHODONTICS</b>		
	50%	50%
<b>ORTHODONTICS AGE LIMIT</b>	Up to Age 19	
<b>ORTHODONTICS LIFETIME MAXIMUM</b>	\$1500	
<b>CALENDAR YEAR DEDUCTIBLE</b> (waived for Preventive)		
Individual	\$50	\$50
Family	\$150	\$150
<b>CALENDAR YEAR MAXIMUM</b>	\$1500	\$1500
<b>OUT OF POCKET MAXIMUM</b>	N/A	N/A
<b>MAXIMUM ROLLOVER</b>	\$1250	
<b>DEPENDENT AGE LIMIT</b>	26	
<b>OUT OF NETWORK REIMBURSEMENT*</b>	MAC	
<b>WAITING PERIODS</b>	None	

\* Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

*Plan will pay either the Participating Dentist's negotiated fee or the Maximum Allowable Charge (subject to benefit coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.*

## **Benefits**

You have the right to benefits on a non-discriminatory basis for the following services, EXCEPT as limited or excluded elsewhere in this Subscriber Certificate. The benefits are limited to a maximum dollar payment for each *covered individual* for each benefit period. The extent of your benefits is explained in the *Schedule of Benefits* your *Plan Sponsor* has purchased and which is incorporated as a part of this Subscriber Certificate.

- Initial oral examination (including the initial dental history and charting of teeth); once per dentist.
- Periodic exam; once every six (6) months.
- X-rays of the entire mouth; once every sixty (60) months.
- Bitewing x-rays (x-rays of the crowns of the teeth); once every six (6) months or when oral conditions indicate need.
- Single tooth x-rays; as needed.
- Study models and casts used in planning treatment; once every sixty (60) months.
- Routine cleaning, scaling and polishing of teeth; once every six (6) months.
- Periodontal maintenance, including cleaning and scaling and root planing procedures, following active periodontal therapy when preceded by active periodontal therapy.
- Fluoride treatment for children under nineteen (19) years; once every six (6) months.
- Fluoride treatment for adults following osseous surgery or new decay.
- Space maintainers required due to the premature loss of teeth; only for children under age fourteen (14) and not for the replacement of primary or permanent anterior teeth.
- Sealants on unrestored permanent molars; once per tooth for children through age fifteen (15).
- Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each twenty-four (24) month period. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist's charge. No benefits are provided for replacing a filling within twenty-four (24) months of the date that the prior filling was furnished.
- Sedative fillings; once per tooth.
- Stainless steel crowns on deciduous (baby) teeth; once every twenty-four (24) months.
- Simple tooth extractions.
- General anesthesia only when necessary and appropriate for covered surgical services only when provided by a licensed, practicing dentist.
- Repair of dentures or fixed bridges; once every

twelve (12) months. Recementing of fixed bridges; once each twelve (12) months.

- Rebase or reline dentures; once every thirty-six (36) months.
- Tissue conditioning; two treatments every thirty-six (36) months.
- Repair or recement crowns and onlays. Recementing is limited to once every twelve (12) months per tooth.
- Adding teeth to existing partial or full dentures.
- Palliative (emergency) treatment of dental pain – minor procedures.
- Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth.
- Periodontal services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery).
- Endodontic services for root canal treatment of permanent teeth except for permanent molars including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth.
- Dentures and Bridges
  - Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once every sixty (60) months.
  - Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.
  - Temporary partial dentures as follows:
    - To replace any of the six (6) upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.
    - For the replacement of permanent teeth for Covered Individuals who are under sixteen (16) years.
- Crowns and Onlays as follows, but only when the teeth cannot be restored with the fillings described in the Schedule of Benefits due to severe decay or fractures:
  - Initial placement of crowns and onlays.
  - Replacement of crowns and onlays; once each sixty (60) months per tooth.
- Endosteal implant, a device surgically inserted into the bone to provide support for a single restoration when used in lieu of a three unit bridge and adjacent abutment teeth are not to be restored, age sixteen (16) or older, once per tooth per sixty (60) months.

## **Limitations and Exclusions**

### **1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES**

We will not provide benefits for a dental service that is not covered under the terms of the Subscriber Certificate. We will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition. We will not cover experimental care procedures that have not been sanctioned by the American Dental Association and for which no procedure codes have been established.

A. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist.

B. Who determines what is necessary and appropriate under the terms of the Subscriber Certificate: That decision is made based on a review of dental records describing your condition and treatment. We may decide a service is not necessary and appropriate under the terms of the Subscriber Certificate even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

### **2. WE DO NOT PROVIDE BENEFITS FOR:**

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Subscriber Certificate.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Subscriber Certificate.
- An illness, injury or dental condition for which benefits in one form or another are covered, in whole or in part, through a government program. A government program includes a local, state or national law or

regulation that provides or pays for dental services. It does not include Medicaid or Medicare.

- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition.
- Services that are meant primarily to change or to improve your appearance.
- Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding).
- Repair or reline of an occlusal guard.
- Implants, other than covered endosteal implants.
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary, complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing over dentures.
- Services related to congenital anomalies. However, this exclusion does not apply to orthodontic services that may be covered by your group's orthodontic rider.
- Tooth desensitization.
- Occlusal adjustment.

## Access ePPO C2

<b>DIAGNOSTIC &amp; PREVENTIVE</b>	
Oral examinations	<b>See Fee Schedule</b>
Teeth cleaning	<b>See Fee Schedule</b>
X-rays	<b>See Fee Schedule</b>
<b>BASIC RESTORATIVE</b>	
Fillings	<b>See Fee Schedule</b>
Simple extractions	<b>See Fee Schedule</b>
Denture repairs	<b>See Fee Schedule</b>
General anesthesia	<b>See Fee Schedule</b>
<b>ENDODONTICS</b>	
Root canals	<b>See Fee Schedule</b>
<b>PERIODONTICS</b>	
Scaling and root planing	<b>See Fee Schedule</b>
Gingivectomy/gingivoplasty	<b>See Fee Schedule</b>
<b>ORAL SURGERY</b>	
Extraction of impacted teeth	<b>See Fee Schedule</b>
<b>MAJOR RESTORATIVE</b>	
Inlays and onlays	<b>See Fee Schedule</b>
Crowns	<b>See Fee Schedule</b>
Dentures	<b>See Fee Schedule</b>
Implants (in lieu of a 3-unit bridge)	<b>See Fee Schedule</b>
Fixed bridges	<b>See Fee Schedule</b>
<b>ORTHODONTICS</b>	
<b>ORTHODONTICS AGE LIMIT</b>	
<b>ORTHODONTICS LIFETIME MAXIMUM</b>	
<b>CALENDAR YEAR DEDUCTIBLE</b> (waived for Preventive)	
Individual	<b>\$25</b>
Family	<b>\$75</b>
<b>CALENDAR YEAR MAXIMUM</b>	
OUT OF POCKET MAXIMUM	<b>N/A</b>
<b>MAXIMUM ROLLOVER</b>	
<b>DEPENDENT AGE LIMIT</b>	
<b>OUT OF NETWORK ALLOWANCE*</b>	
<b>WAITING PERIODS</b>	

## **Limitations and Exclusions**

### **1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES**

We will not provide benefits for a dental service that is not covered under the terms of the Subscriber Certificate. We will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition. We will not cover experimental care procedures that have not been sanctioned by the American Dental Association and for which no procedure codes have been established.

A. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist.

B. Who determines what is necessary and appropriate under the terms of the Subscriber Certificate: That decision is made based on a review of dental records describing your condition and treatment. We may decide a service is not necessary and appropriate under the terms of the Subscriber Certificate even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

### **2. WE DO NOT PROVIDE BENEFITS FOR:**

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Subscriber Certificate.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Subscriber Certificate.
- An illness, injury or dental condition for which benefits in one form or another are covered, in whole or in part, through a government program. A government program includes a local, state or national law or

regulation that provides or pays for dental services. It does not include Medicaid or Medicare.

- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition.
- Services that are meant primarily to change or to improve your appearance.
- Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding).
- Repair or reline of an occlusal guard.
- Implants, other than covered endosteal implants.
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary, complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing over dentures.
- Services related to congenital anomalies. However, this exclusion does not apply to orthodontic services that may be covered by your group's orthodontic rider.
- Tooth desensitization.
- Occlusal adjustment.

# Access ePPO Member Fee Schedule C2

ADA CODE	PROCEDURE DESCRIPTION	MEMBER FEE**
<b>D0100-D0999</b>	<b>DIAGNOSTIC</b>	
	<b>CLINICAL ORAL EXAMINATIONS</b>	
D0120	Periodic oral evaluation – established patient (once every 6 months)	\$0.00
D0140	Limited oral evaluation – problem focused (not to exceed 3 in 6 months)	\$0.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver (once every 6 months for child age 3 or under)	\$0.00
D0150	Comprehensive oral evaluation – new or established patient for first encounter with the dentist/dental office (once per 60 months)	\$0.00
D0160	Detailed and extensive oral evaluation – problem focused, by report (once per 60 months)	\$0.00
D0170	Re-evaluation – limited problem focused (established patient; not a post-op visit; not to exceed 3 in 6 months)	\$0.00
D0180	Comprehensive periodontal evaluation – new or established patient (once per 60 months)	\$0.00
	<b>RADIOGRAPHS</b>	
D0210	Intraoral – complete series including bitewings (once in 60 months)	\$0.00
D0220	Intraoral periapical – first film	\$0.00
D0230	Intraoral periapical – each additional film	\$0.00
D0240	Intraoral occlusal film (2 per 6 months)	\$0.00
D0250	Extraoral – first film (2 per 6 months)	\$0.00
D0260	Extraoral – each additional film (2 per 6 months)	\$0.00
D0270	Bitewing – single film (one series without duplication per 6 months)	\$0.00
D0272	Bitewings – two films (one series without duplication per 6 months)	\$0.00
D0273	Bitewings – three films (one series without duplication per 6 months)	\$0.00
D0274	Bitewings – four films (one series without duplication per 6 months)	\$0.00
D0277	Vertical bitewings – 7 to 8 films (one series without duplication per 6 months)	\$0.00
D0290	Posterior/anterior or lateral skull and facial bone survey film (when dentally necessary)	\$0.00
D0330	Panoramic film (once in 60 months)	\$0.00
	<b>TESTS AND EXAMINATIONS</b>	
D0460	Pulp vitality tests (per visit, not per tooth, for emergencies)	\$0.00
	<b>UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT</b>	
D0999	Chlorhexidine mouth rinse or fluoride toothpaste (twice per year for 2 years; covered only following scaling and root planing (a deep cleaning) and must be dispensed in the dentist's office.)	\$0.00
<b>D1000-D1999</b>	<b>PREVENTIVE</b>	
	<b>DENTAL PROPHYLAXIS (ROUTINE CLEANING)</b>	
D1110	Prophylaxis – adult, age 14 and over (once per 6 months)	\$0.00
D1120	Prophylaxis – child, under age 14 (once per 6 months)	\$0.00
	<b>TOPICAL FLUORIDE TREATMENT (once per 6 months)</b>	
D1203	Topical application of fluoride (excluding prophylaxis), child up to 14th birthday	\$0.00
D1204	Topical application of fluoride (excluding prophylaxis), adult up to 19th birthday	\$0.00
D1206	Topical application of fluoride varnish up to 19th birthday	\$0.00
	<b>OTHER PREVENTIVE SERVICES</b>	
D1351	Sealant on unrestored permanent molars – per tooth (once per 4 years through age 15, or up to age 19 when decay in molar)	\$17.00
	<b>SPACE MAINTENANCE (passive applicances)</b>	
D1510	Space maintainer – fixed unilateral (once per quadrant per lifetime for children under age 14 for replacement of primary or permanent posterior teeth)	\$95.00
D1515	Space maintainer – fixed bilateral (once per arch per lifetime for children under age 14 for replacement of primary or permanent posterior teeth)	\$105.00
D1520	Space maintainer – removable unilateral (once per quadrant per lifetime for children under age 14 for replacement of primary or permanent posterior teeth)	\$95.00
D1525	Space maintainer – removable bilateral (once per arch per lifetime for children under age 14 for replacement of primary or permanent posterior teeth)	\$115.00
D1550	Recementation of space maintainer (once per arch or quadrant for children under age 14)	\$30.00
D1555	Removal of fixed space maintainer (once per arch or quadrant for children under age 14)	\$30.00

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# Access ePPO Member Fee Schedule C2

ADA CODE	PROCEDURE DESCRIPTION	MEMBER FEE**
<b>D2000-D2999</b>	<b>RESTORATIVE</b>	
	<b>AMALGAM RESTORATIONS (includes polishing; one filling per tooth per surface within 24 months)</b>	
D2140	Amalgam, one surface – primary or permanent	\$20.00
D2150	Amalgam, two surfaces – primary or permanent	\$30.00
D2160	Amalgam, three surfaces – primary or permanent	\$40.00
D2161	Amalgam, four or more surfaces – primary or permanent	\$55.00
	<b>RESIN-BASED COMPOSITE RESTORATIONS (includes acid-etch, light cure &amp; resin bonding; one filling per tooth per surface once within 24 month period)</b>	
D2330	Resin-based composite – one surface, anterior	\$32.00
D2331	Resin-based composite – two surfaces, anterior	\$42.00
D2332	Resin-based composite – three surfaces, anterior	\$52.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle, anterior	\$100.00
D2390	Resin-based composite crown – anterior	\$70.00
D2391	Resin-based composite, one surface, posterior	\$45.00
D2392	Resin-based composite, two surfaces, posterior	\$55.00
D2393	Resin-based composite, three surfaces, posterior	\$65.00
D2394	Resin-based composite, four or more surfaces, posterior	\$115.00
	<b>INLAY/ONLAY RESTORATIONS (cast/laboratory restorations once every 60 months)</b>	
D2510	Inlay – metallic – one surface	\$261.00
D2520	Inlay – metallic – two surfaces	\$336.00
D2530	Inlay – metallic – three or more surfaces	\$375.00
D2542	Onlay – metallic – two surfaces (must be 12 or older)	\$355.00
D2543	Onlay – metallic – three surfaces (must be 12 or older)	\$375.00
D2544	Onlay – metallic – four or more surfaces (must be 12 or older)	\$391.00
D2610	Inlay – porcelain/ceramic – one surface	\$317.00
D2620	Inlay – porcelain/ceramic – two surfaces	\$331.00
D2630	Inlay – porcelain/ceramic – three or more surfaces	\$374.00
D2642	Onlay – porcelain/ceramic – two surfaces (must be 12 or older)	\$375.00
D2643	Onlay – porcelain/ceramic – three surfaces (must be 12 or older)	\$391.00
D2644	Onlay – porcelain/ceramic four or more surfaces (must be 12 or older)	\$393.00
D2650	Inlay – composite/resin – one surface (laboratory processed)	\$317.00
D2651	Inlay – composite/resin – two surfaces (laboratory processed)	\$331.00
D2652	Inlay – composite/resin – three or more surfaces (laboratory processed)	\$374.00
D2662	Onlay – composite/resin – two surfaces (laboratory processed; must be 12 or older)	\$375.00
D2663	Onlay – composite/resin – three surfaces (laboratory processed; must be 12 or older)	\$391.00
D2664	Onlay – composite/resin – four or more surfaces (laboratory processed; must be 12 or older)	\$393.00
	<b>CROWNS – SINGLE RESTORATIONS (once every 60 months except children under age 12)</b>	
D2710	Crown – resin (indirect)	\$433.00
D2712	Crown – 3/4 resin based composite (indirect) does not include facial veneers	\$433.00
D2720	Crown – resin with high noble metal	\$465.00
D2721	Crown – resin with predominantly base metal	\$450.00
D2722	Crown – resin with noble metal	\$450.00
D2740	Crown – porcelain/ceramic substrate	\$545.00
D2750	Crown – porcelain fused to high noble metal	\$570.00
D2751	Crown – porcelain fused to predominantly base metal	\$520.00
D2752	Crown – porcelain fused to noble metal	\$520.00
D2780	Crown – 3/4 cast high noble metal	\$393.00
D2781	Crown – 3/4 cast predominantly base metal	\$368.00
D2782	Crown – 3/4 cast noble metal	\$391.00
D2783	Crown – 3/4 porcelain/ceramic	\$400.00
D2790	Crown – full cast high noble metal	\$507.00
D2791	Crown – full cast predominantly base metal	\$455.00
D2792	Crown – full cast noble metal	\$473.00
D2794	Crown – titanium	\$530.00
	<b>OTHER RESTORATIVE SERVICES</b>	
D2910	Recement inlay (after 6 months of initial placement)	\$34.00
D2915	Recement cast or prefabricated post and core (once in lifetime)	\$34.00
D2920	Recement crown (once every 12 months per tooth after 6 months of initial placement)	\$27.00
D2930	Prefabricated stainless steel crown – primary tooth (once every 24 months)	\$90.00

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ADA CODE	PROCEDURE DESCRIPTION	MEMBER FEE**
<b>D2000-D2999</b>	<b>RESTORATIVE – Continued</b>	
D2931	Prefabricated stainless steel crown – permanent tooth (once every 24 months)	\$90.00
D2932	Prefabricated resin crown (once every 24 months on anterior primary tooth)	\$66.00
D2933	Prefabricated stainless steel crown with resin window. Open face stainless steel crown with aesthetic resin facing or veneer. (once every 24 months on anterior primary tooth)	\$84.00
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth (once every 24 months on anterior primary tooth)	\$84.00
D2940	Sedative filling – once per tooth; excluded when definitive restoration is performed on tooth	\$30.00
D2950	Core build-up, including any pins (once per tooth per 60 months)	\$100.00
D2951	Pin retention – per tooth, in addition to restoration (once per permanent tooth during same appointment for restoration)	\$28.00
D2952	Post and core in addition to crown, indirectly fabricated (once per tooth, per 60 months)	\$141.00
D2953	Each additional indirectly fabricated post, same tooth, indirectly fabricated	\$77.00
D2954	Prefabricated post and core in addition to crown (once per tooth per 60 months)	\$105.00
D2961	Labial veneer (resin laminate) – laboratory (not covered if considered cosmetic; once per 60 months)	\$285.00
D2962	Labial veneer (porcelain laminate) – laboratory (not covered if considered cosmetic; once per 60 months)	\$436.00
D2970	Temporary crown – fractured tooth, by report (may be covered when treatment is definitive and no other restoration is planned)	\$104.00
D2971	Additional procedures to construct new crown under existing partial denture framework (once per tooth per 60 months)	\$54.00
D2980	Crown repair, by report (once per tooth per 12 months) after 6 months of initial placement	\$85.00
<b>D3000-D3999</b>	<b>ENDODONTICS</b>	
	<b>PULP CAPPING (excluding final restoration or sedative filling for same tooth)</b>	
D3110	Pulp cap direct	\$13.00
D3120	Pulp cap indirect	\$13.00
	<b>PULPOTOMY</b>	
D3220	Therapeutic pulpotomy (only on primary teeth, excluding final restoration; once per tooth per lifetime)	\$100.00
D3221	Gross pulpal debridement primary and permanent teeth (once per tooth per lifetime)	\$100.00
	<b>ENDODONTIC THERAPY</b>	
D3222	Therapeutic pulpotomy (once per permanent tooth per lifetime for patients under 19 years)	\$100.00
D3230	Pulpal therapy (resorbable filling) anterior primary tooth (excluding final restoration and on primary molar without a permanent successor)	\$90.00
D3240	Pulpal therapy (resorbable filling) posterior primary tooth (excluding final restoration and on primary molar without a permanent successor)	\$102.00
	<b>ENDODONTIC THERAPY (includes treatment plan, clinical procedures, and follow-up care)</b>	
D3310	Anterior (excluding final restoration) retreatment not before 24 months	\$550.00
D3320	Bicuspid (excluding final restoration) retreatment not before 24 months	\$640.00
D3330	Molar (excluding final restoration) retreatment not before 24 months	\$780.00
D3331	Treatment of root canal obstruction; non-surgical access	\$127.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$234.00
D3333	Internal root repair of perforation defects	\$119.00
	<b>ENDODONTIC RETREATMENT (includes complete root canal therapy)</b>	
D3346	Retreatment of previous root canal therapy, anterior, by report (once per tooth after 24 months)	\$569.00
D3347	Retreatment of previous root canal therapy, bicuspid, by report (once per tooth after 24 months)	\$658.00
D3348	Retreatment of previous root canal therapy, molar, by report (once per tooth after 24 months)	\$776.00
D3351	Apexification/recalcification – initial visit. (apical closure/calcific repair of perforations, root resorption, etc.) for permanent teeth and must follow 4–6 months of healing or narrowing of canal	\$170.00
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) for permanent teeth and must follow 4–6 months of healing or narrowing of canal	\$83.00
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	\$179.00
D3410	Apicoectomy/periradicular surgery – anterior (once per tooth)	\$414.00

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ADA CODE	PROCEDURE DESCRIPTION	MEMBER FEE**
<b>D3000-D3999</b>	<b>ENDODONTICS – Continued</b>	
D3421	Apicoectomy/periradicular surgery – bicuspid (first root; once per tooth)	\$446.00
D3425	Apicoectomy/periradicular surgery – molar (first root; once per tooth)	\$543.00
D3426	Apicoectomy/periradicular surgery – (each additional root; must be submitted with D3421 or D3425 on same date of service)	\$145.00
D3430	Retrograde filling (one per root up to maximum of 2 retrogrades on a molar)	\$138.00
D3450	Root amputation – per root (once per posterior tooth)	\$258.00
D3920	Hemisection (including any root removal), not including root canal therapy (once per posterior tooth)	\$194.00
<b>D4000-D4999</b>	<b>PERIODONTICS (Limited to 2 Quadrants per Date of Service)</b>	
	<b>SURGICAL SERVICES (includes usual post-operative care)</b>	
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth bounded spaces per quadrant for 5 mm or greater pocketing (once per quadrant per 36 months)	\$198.00
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant for 5 mm or greater pocketing (once per tooth per 36 months)	\$100.00
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant for 5mm or greater pocketing (once per quadrant per 36 months)	\$368.00
D4241	Gingival flap procedure, including root planning one to three contiguous teeth or tooth bounded spaces with 5mm or greater pocketing per quadrant (once per tooth per 36 months)	\$221.00
D4249	Clinical crown lengthening – hard tissue (covered when bone removed, once per tooth per 60 months)	\$379.00
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces with 5mm or greater pocketing, once per quadrant per 36 months	\$600.00
D4261	Osseous surgery (including flap and closure) – one to three contiguous teeth or tooth bounded spaces with 5mm or greater pocketing, once per quadrant per 36 months	\$360.00
D4263	Bone replacement graft – first site in quadrant (once per site per 36 months)	\$230.00
D4264	Bone replacement graft – each additional site in quadrant, not to exceed 2 sites in a quadrant (once per site per 36 months)	\$134.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration (once per site per 36 months)	\$194.00
D4266	Guided tissue regeneration – resorbable barrier, per site (not to exceed 2 sites in a quadrant per 36 months)	\$341.00
D4267	Guided tissue regeneration – non-resorbable barrier, per site, (includes membrane removal; not to exceed 2 sites in a quadrant per 36 months)	\$358.00
D4270	Pedicle soft tissue graft procedure (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	\$401.00
D4271	Free soft tissue graft procedure (including donor site surgery; once per tooth per 36 months, not to exceed 2 teeth per 36 months)	\$401.00
D4273	Subepithelial connective tissue graft procedures (including donor site surgery; once per tooth per 36 months, not to exceed 2 teeth per 36 months)	\$626.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area; once per site per 36 months)	\$194.00
D4275	Soft tissue allograft, per site (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	\$405.00
D4276	Combined connective tissue and double pedicle graft (once per tooth per 36 months, not to exceed 2 teeth per 36 months)	\$544.00
	<b>NON-SURGICAL SERVICES (includes usual post-operative costs)</b>	
D4341	Periodontal scaling and root planing – four or more teeth per quadrant with 4 mm pocketing (once per quadrant per 24 months)	\$97.00
D4342	Periodontal scaling and root planing – (once per quad per 24 months; one to three teeth per quadrant)	\$52.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis (once)	\$60.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue (Once per tooth per 24 months 4 weeks after scaling and root planing)	\$42.00

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<b>D4000-D4999</b>	<b>PERIODONTICS (Limited to 2 Quadrants per Date of Service) – Continued</b>	
<b>OTHER PERIODONTAL SERVICES</b>		
D4910	Periodontal maintenance procedures (following active therapy) (once per 3 months following active periodontal therapy)	\$75.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	\$49.00
<b>D5000-D5999</b>	<b>PROSTHODONTICS (removable)</b>	
<b>COMPLETE DENTURES (includes routine post-delivery care)</b>		
D5110	Complete denture – maxillary (once per 60 months)	\$560.00
D5120	Complete denture – mandibular (once per 60 months)	\$560.00
D5130	Immediate denture – maxillary (once per lifetime)	\$565.00
D5140	Immediate denture – mandibular (once per lifetime)	\$565.00
<b>PARTIAL DENTURES (includes routine post-delivery care; once per arch per 60 months after 6 months from initial placement)</b>		
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	\$375.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	\$375.00
D5213	Maxillary partial denture – case metal framework with resin saddles (including any conventional clasps, rests, and teeth)	\$625.00
D5214	Mandibular partial denture – cast metal framework and resin saddles (including any conventional clasps, rests, and teeth)	\$625.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	\$625.00
D5226	Mandibular partial denture – flexible base (including clasps, rests and teeth)	\$625.00
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and arch)	\$318.00
<b>ADJUSTMENTS TO DENTURES (2 adjustments per denture per 12 months after 6 months from initial placement)</b>		
D5410	Adjust complete denture – maxillary	\$20.00
D5411	Adjust complete denture – mandibular	\$20.00
D5421	Adjust partial denture – maxillary	\$20.00
D5422	Adjust partial denture – mandibular	\$20.00
<b>REPAIRS TO COMPLETE DENTURES</b>		
D5510	Repair broken complete denture base (once per arch per 12 months)	\$59.00
D5520	Replace missing or broken teeth (once per tooth per 12 months)	\$65.00
<b>REPAIRS TO PARTIAL DENTURES</b>		
D5610	Repair resin denture base (once per arch per 12 months)	\$59.00
D5620	Repair cast framework (once per arch per 12 months)	\$59.00
D5630	Repair or replace broken clasp (once per tooth per 12 months)	\$59.00
D5640	Repair broken teeth – per tooth (once per tooth per 12 months)	\$65.00
D5650	Add tooth to existing partial denture (once per tooth per 12 months)	\$65.00
D5660	Add clasp to existing partial denture (once per tooth per 12 months)	\$70.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary; once in 60 months)	\$245.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular; once in 60 months)	\$245.00
<b>DENTURE REBASE PROCEDURES (once per arch per 36 months after 6 months from insertion)</b>		
D5710	Rebase complete maxillary denture	\$185.00
D5711	Rebase complete mandibular denture	\$185.00
D5720	Rebase maxillary partial denture	\$110.00
D5721	Rebase mandibular partial denture	\$110.00
<b>DENTURE RELINE PROCEDURES (per arch per 36 months after 6 months from insertion)</b>		
D5730	Reline complete maxillary denture (chair side)	\$93.00
D5731	Reline complete mandibular denture (chair side)	\$93.00
D5740	Reline maxillary partial denture (chair side)	\$93.00
D5741	Reline mandibular partial denture (chair side)	\$93.00
D5750	Reline complete maxillary denture (laboratory)	\$134.00
D5751	Reline complete mandibular denture (laboratory)	\$134.00
D5760	Reline maxillary partial denture (laboratory)	\$134.00
D5761	Reline mandibular partial denture (laboratory)	\$134.00

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<b>D5000-D5999</b>	<b>PROSTHODONTICS (removable) – Continued</b>	
	<b>INTERIM PROSTHESIS</b>	
D5820	Interim partial denture – maxillary (for replacement of anterior teeth during healing; once in 60 months)	\$228.00
D5821	Interim partial denture – mandibular (for replacement of anterior teeth during healing; once in 60 months)	\$228.00
D5850	Tissue conditioning (maxillary; up to twice per denture unit per 36 months)	\$41.00
D5851	Tissue conditioning (mandibular; up to twice per denture unit per 36 months)	\$41.00
D5860	Overdenture – complete, by report (once per arch per 60 months)	\$600.00
D5861	Overdenture – partial, by report (once per arch per 60 months)	\$565.00
<b>D6000-D6199</b>	<b>IMPLANT SERVICES</b>	
D6010	Surgical placement of implant body: endosteal implant (in lieu of 3 unit bridge; for age 16 and older; once per tooth per 60 months)	\$1,360.00
	<b>IMPLANT SUPPORTED PROSTHETICS (Once per tooth per 60 months)</b>	
D6056	Prefabricated abutment (includes placement)	\$468.00
D6057	Custom abutment (includes placement)	\$560.00
D6058	Abutment supported porcelain/ceramic crown	\$705.00
D6059	Abutment supported porcelain fused to metal crown (high noble)	\$665.00
D6060	Abutment supported porcelain fused to metal crown (base metal)	\$600.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$640.00
D6062	Abutment supported cast metal crown (high noble)	\$632.00
D6063	Abutment supported cast metal crown (base metal)	\$600.00
D6064	Abutment supported cast metal crown (noble metal)	\$620.00
D6065	Implant supported porcelain/ceramic crown	\$705.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	\$665.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	\$665.00
D6094	Abutment supported crown (titanium)	\$640.00
	<b>REPAIRS, RECEMENT, OR REMOVAL</b>	
D6090	Repair implant supported prosthesis, by report (once in 12 months per tooth)	\$76.00
D6092	Recement implant/abutment supported crown (once per tooth after 6 months from initial placement)	\$24.00
D6093	Recement implant/abutment supported fixed partial denture (once in 12 months after 6 months from initial placement)	\$35.00
D6095	Repair implant abutment, by report (once per year after 24 months of initial placement)	\$140.00
D6100	Implant removal, by report (once per tooth)	\$116.00
<b>D6200-D6999</b>	<b>PROSTHODONTICS, FIXED (Each retainer and each pontic constitutes a unit in a fixed partial denture. For age 16 and older. Once per tooth per 60 months, unless otherwise noted.)</b>	
	<b>FIXED PARTIAL DENTURE PONTICS</b>	
D6205	Pontic – indirect resin based composite	\$520.00
D6210	Pontic – cast high noble	\$510.00
D6211	Pontic – cast predominantly base metal	\$463.00
D6212	Pontic – cast noble metal	\$473.00
D6214	Pontic – titanium	\$520.00
D6240	Pontic – porcelain fused to high noble metal	\$570.00
D6241	Pontic – porcelain fused to predominantly base metal	\$520.00
D6242	Pontic – porcelain fused to noble metal	\$520.00
D6245	Pontic – porcelain ceramic substrate	\$500.00
D6250	Pontic – resin with high noble metal	\$552.00
D6251	Pontic – resin with predominantly base metal	\$442.00
D6252	Pontic – resin with noble metal	\$508.00
	<b>FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS</b>	
D6545	Retainer – cast metal for resin bonded fixed prosthesis	\$251.00
D6602	Inlay – cast high noble metal two surfaces	\$344.00
D6603	Inlay – cast high noble metal three or more surfaces	\$379.00
D6604	Inlay – cast predominantly base metal two surfaces	\$394.00

## SYMBOL KEY

\* The listed Customary Fee is for illustrative purposes only. Customary fees may vary by dentist and by geographic area.

\*\* Member Fee when performed by a Participating Dentist.

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# Access ePPO Member Fee Schedule C2

ADA CODE	PROCEDURE DESCRIPTION	MEMBER FEE**
<b>D6200-D6999</b>	<b>PROSTHODONTICS, FIXED (Each retainer and each pontic constitutes a unit in a fixed partial denture. For age 16 and older. Once per tooth per 60 months, unless otherwise noted.) – Continued</b>	
D6605	Inlay – cast predominantly base metal three or more surfaces	\$379.00
D6606	Inlay – cast noble metal two surfaces	\$394.00
D6607	Inlay – cast noble metal three or more surfaces	\$379.00
D6610	Onlay – cast high noble metal two surfaces	\$415.00
D6611	Onlay – cast high noble metal three or more surfaces	\$401.00
D6612	Onlay – cast predominantly base metal two surfaces	\$415.00
D6613	Onlay – cast predominantly base metal three or more surfaces	\$401.00
D6614	Onlay – cast noble metal two surfaces	\$415.00
D6615	Onlay – cast noble metal three or more surfaces	\$401.00
D6624	Inlay – titanium	\$401.00
D6634	Onlay – titanium	\$401.00
<b>FIXED PARTIAL DENTURE RETAINERS – CROWNS</b>		
D6710	Crown – indirect resin based composite	\$502.00
D6720	Crown – resin with high noble metal	\$446.00
D6721	Crown – resin with predominantly base metal	\$425.00
D6722	Crown – resin with noble metal	\$425.00
D6740	Crown – porcelain/ceramic	\$506.00
D6750	Crown – porcelain fused to high noble	\$520.00
D6751	Crown – porcelain fused to predominantly base metal	\$475.00
D6752	Crown – porcelain fused to noble metal	\$475.00
D6780	Crown – 3/4 cast high noble metal	\$410.00
D6781	Crown – 3/4 cast predominately based metal	\$375.00
D6782	Crown – 3/4 cast noble metal	\$404.00
D6790	Crown – full cast high noble metal	\$512.00
D6791	Crown – full cast predominantly base metal	\$446.00
D6792	Crown – full cast noble metal	\$473.00
D6793	Provisional retainer crown (If used at least 6 months during multistage care)	\$156.00
D6794	Crown – titanium	\$502.00
<b>OTHER FIXED PARTIAL DENTURE SERVICES</b>		
D6930	Re cement fixed bridge (once every 12 months after 6 months from initial placement)	\$50.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$138.00
D6972	Prefabricated post and core in addition to bridge retainer	\$116.00
D6973	Core build-up for retainer, including any pins (not covered in conjunction with D6970 and D6972)	\$116.00
D6977	Each additional prefabricated post – same tooth	\$64.00
D6980	Bridge repair, by report (once every 12 months)	\$100.00
D6985	Pediatric partial denture – fixed (once per arch per 60 months)	\$375.00
<b>D7000-D7999</b>	<b>ORAL AND MAXILLOFACIAL SURGERY</b>	
D7111	Extraction coronal remnants – deciduous tooth (once per tooth)	\$40.00
D7140	Extraction – erupted tooth or exposed roots (elevation and/or forceps removal; once per tooth)	\$50.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth (once per tooth)	\$104.00
D7220	Removal of impacted tooth – soft tissue (once per tooth)	\$130.00
D7230	Removal of impacted tooth – partially bony (once per tooth)	\$190.00
D7240	Removal of impacted tooth – completely bony (once per tooth)	\$225.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications (once per tooth)	\$235.00
D7250	Surgical removal of residual tooth roots (once per tooth)	\$120.00
D7260	Oroantral fistula closure	\$689.00
D7261	Primary closure of a sinus perforation	\$200.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus (once per tooth)	\$414.00
D7285	Biopsy of oral tissue – hard (bone, tooth)	\$253.00
D7286	Biopsy of oral tissue – soft	\$259.00
D7287	Exfoliative cytological sample collection	\$50.00
D7288	Brush biopsy – transepithelial sample collection	\$40.00
D7310	Alveoloplasty in conjunction with extractions – per quadrant (once per quadrant per lifetime)	\$201.00

## SYMBOL KEY

\* The listed Customary Fee is for illustrative purposes only. Customary fees may vary by dentist and by geographic area.

\*\* Member Fee when performed by a Participating Dentist.

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# Access ePPO Member Fee Schedule C2

ADA CODE	PROCEDURE DESCRIPTION	MEMBER FEE**
<b>D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY – Continued</b>		
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces per quadrant (once per quadrant)	\$132.00
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces per quadrant (no extractions performed in a quadrant; once per quadrant)	\$276.00
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces per quadrant (once per quadrant)	\$228.00
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	\$690.00
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$1,322.00
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure (once per site)	\$322.00
D7963	Frenuoplasty (once per site)	\$322.00
D7970	Excision of hyperplastic tissue – per arch	\$322.00
D7971	Excision of pericoronal gingiva	\$106.00
D7980	Sialolithotomy	\$644.00
D7981	Excision of salivary gland, by report	\$2,300.00
D7982	Sialodochoplasty	\$1,380.00
D7983	Closure of salivary fistula	\$1,196.00
<b>D9000-D9999 ADJUNCTIVE GENERAL SERVICES</b>		
<b>UNCLASSIFIED TREATMENT</b>		
D9110	Palliative (emergency) treatment of dental pain – minor procedure (per visit basis, once on same date; limit 3 times per 12 months)	\$35.00
D9120	Fixed partial denture sectioning (once per tooth)	\$35.00
<b>ANESTHESIA</b>		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$14.00
D9220	Deep sedation/general anesthesia – up to 30 minutes (covered when administered with covered surgery)	\$160.00
D9221	Deep sedation/general anesthesia – each additional 15 minutes (covered when administered with covered surgery)	\$65.00
D9241	Intravenous conscious sedation/analgesia – up to 30 minutes (covered when administered with covered surgery)	\$115.00
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes (covered when administered with covered surgery by licensed dentist in a dental office)	\$55.00
D9248	Non-Intravenous conscious sedation	\$89.00
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician (not covered in conjunction with an examination/evaluation)	\$40.00
D9940	Occlusal guard, by report (includes adjustments or repairs 6 months after delivery; once in 60 months when delivered within 36 months following active periodontal treatment)	\$220.00
D9942	Repair or reline of an occlusal guard (Only when D9940 has been benefited and after 6 months of initial placement)	\$82.00
<b>PLAN PROVISIONS</b>		
1.	Referral Forms are not required to see Participating Specialists.	
2.	Recognized and accepted ADA-CDT procedure codes must be used when reporting treatment and assessing member fees. Use of alternative or new materials must correspond to a recognized ADA-CDT procedure code.	
3.	Procedures "Not Covered" by the Plan may be charged at the Participating Dentist's usual and customary fee(s).	
4.	Dental procedures performed solely for esthetic or cosmetic reasons are not covered services under the Plan, and the patient may be charged the Participating Dentist's usual and customary fee(s).	
5.	It is recommended that Participating Dentist's contact the Plan, or submit a pre-treatment estimate, prior to providing treatment for services of \$600.00 or more.	
6.	Patient will be liable for all hospital costs in the event dental treatment is provided in a hospital.	
7.	Fluoride Toothpaste is only covered following periodontal surgery and must be dispensed in the dentist's office.	
8.	Recement or repair onlay falls under procedure codes D2920 (Recement crown) or D2980 (Crown repair).	
9.	No benefits are provided for dental services rendered by a non-plan participating dentist, except in the case of an out-of-area emergency or when the Plan has given the member a referral to a non-plan participating dentist. For these exceptions, the member is responsible for filing claims forms for reimbursement.	
10.	Plan benefits may be verified by contacting the Dominion USA Member Services Department at 800-334-6277.	
<b>SYMBOL KEY</b>		
* The listed Customary Fee is for illustrative purposes only. Customary fees may vary by dentist and by geographic area.		
** Member Fee when performed by a Participating Dentist.		
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# Access ePPO Member Fee Schedule C2 - additional fees

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ADA CODE	PROCEDURE DESCRIPTION	MEMBER FEE(S)
D3950	Canal prep/fitting of preformed dowel or post .....	0
D7510	Incision/drainage of abscess - intraoral soft.....	175
D9215	Local anesthesia .....	0
D9980	Sterilization surcharge.....	0

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*Life/AD&D*  
&  
*Voluntary Life/AD&D*  
Mutual of Omaha



# TERM LIFE AND AD&D INSURANCE BENEFITS SUMMARY



## **For Employees of Graduate School USA**

## **ELIGIBILITY - ALL ELIGIBLE EMPLOYEES**

<b>Eligibility Requirement</b>	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
<b>Minimum Work Hours</b>	You must be working a minimum of 40 hours per week to be eligible for coverage.
<b>Coverage Payment</b>	Your employer pays 100% of the premium for this coverage.

**GUARANTEE ISSUE AMOUNT(S)**

**For You** \$50,000

*Note: Subject to any reductions shown below, guarantee issue means the amount of insurance applied for which does not require evidence of insurability. Guarantee Issue is available to New Hires only. For New Hires, coverage amounts over the Guarantee Issue Amount will require a health application/evidence of insurability. For Late Entrants, all coverage amounts will require a health application/evidence of insurability.*

## BENEFITS

BENEFITS	
<b>Life Insurance Benefit Amount</b>	For You: An amount equal to 1times your annual salary, up to \$50,000  <i>* In the event of death, the benefit paid will equal the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.</i>
<b>Accidental Death &amp; Dismemberment (AD&amp;D) Benefit Amount</b>	For You: The Principal Sum amount is equal to the amount of life insurance benefit.

## FEATURES

*Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.*

## AGE REDUCTIONS AND EXCLUSIONS

Your life insurance benefits and guarantee issue amounts are subject to age reductions. At age 65, amounts reduce to 65%. At age 70+, amounts reduce to 50%. Coverage terminates at retirement.

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

*This information describes some of the features of the benefit plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan.*

Please contact your employer if you have questions prior to enrolling.

This information describes some of the features of the benefits plan. Benefits may not be available in all plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the

*life insurance and accidental death & dismemberment insurance are underwritten by United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175. United of Omaha Life Insurance Company is licensed in every state except New York. Term Life Policy Form Number 7000GM-C-EZ-2001. AD&D Policy Form Number 7000M-M-EZ 2001.*

## **VOLUNTARY TERM LIFE AND AD&D INSURANCE BENEFITS SUMMARY**



## **For Employees of Graduate School USA**

## **ELIGIBILITY - ALL ELIGIBLE EMPLOYEES**

<b>Eligibility Requirement</b>	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.		
<b>Dependent Eligibility Requirements</b>	To be eligible for coverage, your dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility).		
<b>Minimum Work Hours</b>	You must be working a minimum of 40 hours per week to be eligible for coverage.		
<b>Coverage Payment</b>	You pay 100% of the premium for this coverage through easy payroll deduction.		
<b>COVERAGE GUIDELINES</b>			
	<b>Employee</b>	<b>Spouse</b>	<b>Child(ren)</b>
<b>Minimum</b>	1X annual salary	\$5,000	\$2,000
<b>Maximum</b>	3X annual salary, up to \$500,000	100% of employee's benefit, up to \$100,000	100% of employee's benefit, up to \$10,000
<b>Guarantee Issue Amount</b>	3X annual salary, up to \$150,000	100% of employee's benefit, up to \$25,000	100% of employee's benefit, up to \$10,000

**Note:** Subject to any reductions shown below, Guarantee Issue means the amount of insurance applied for which does not require evidence of insurability. Guarantee Issue is available to New Hires only. For New Hires, coverage amounts over the Guarantee Issue Amount will require a health application/evidence of insurability. For Late Entrants, all coverage amounts will require a health application/evidence of insurability.

## BENEFITS

<b>Life Insurance Benefit Amount</b>	<p>Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. For you (the employee), you have coverage options of one, two or three times your annual salary.</p> <p>This plan includes the option to select coverage for your spouse and dependent child(ren). Children include those 14 days old, up to age 21 (25 if a full-time student).</p> <p><i>Note: In the event of death, the benefit paid will equal the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.</i></p>
<b>Accidental Death &amp; Dismemberment (AD&amp;D) Benefit Amount</b>	<p>For you, your spouse and your dependent child(ren): The Principal Sum amount is equal to the amount of the life insurance benefit.</p> <p>AD&amp;D coverage is available if you or your dependents are injured or die as a result of an accident, and the injury or death is independent of sickness and all other causes. The benefit amount depends on the type of loss incurred, and is either all or a portion of the Principal Sum.</p>

## FEATURES

## FEATURES (CONTINUED)

<b>Conversion</b>	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
<i>Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.</i>	
<b>AGE REDUCTIONS AND EXCLUSIONS</b>	
Your life insurance benefits and guarantee issue amounts are subject to age reductions. At age 70, amounts reduce to 65%. At age 75, amounts reduce to 45%. At age 80, amounts reduce to 30%. At age 85, amounts reduce to 20%. At age 90+, amounts reduce to 15%. Spouse coverage terminates at age 70. Coverage terminates at retirement.	
Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date of issue (the date coverage begins) of this coverage. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.	
Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.	
Please contact your employer if you have questions prior to enrolling.	

*This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by Mutual of Omaha. Term life insurance and accidental death & dismemberment insurance are underwritten by United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175. United of Omaha Life Insurance Company is licensed in every state except New York. Term Life Policy Form Number 7000GM-C-EZ-2001. AD&D Policy Form Number 7000M-M-EZ 2001.*

## COVERAGE SELECTION AND PREMIUM CALCULATION - EMPLOYEE

Use the rates in the Age/Rate Table to calculate your benefit and premium for Voluntary Term Life coverage in the worksheet below, using the example as a guide.

<b>Age/Rate Table</b>	
<b>Age</b>	<b>Rate (per \$1,000 of coverage)</b>
<b>0 - 29</b>	\$.09
<b>30 - 34</b>	\$.11
<b>35 - 39</b>	\$.14
<b>40 - 44</b>	\$.17
<b>45 - 49</b>	\$.23
<b>50 - 54</b>	\$.37
<b>55 - 59</b>	\$.65
<b>60 - 64</b>	\$.82
<b>65 - 69</b>	\$1.30
<b>70+</b>	\$2.09

### Benefit and Premium Calculation Example

*This example is for 42-year-old employee, earning \$41,676.51 a year.*

A. Enter your annual salary*	\$41,676.51
B. Determine the amount of coverage you want: Enter 1 for one times salary, 2 for two times salary, 3 for three times salary	3
C. Multiply "A" times "B"	\$125,029.53
D. Round "C" up to the next higher \$1,000	\$126,000
E. Enter the Maximum coverage amount (3.00 times "A" rounded up to the next higher \$1,000, or \$500,000, whichever is less)	\$126,000
F. Enter the lesser of "D" or "E"; This is your benefit amount	\$126,000
G. Divide "F" by 1,000	126
H. Enter the rate for your age (from the Age/Rate Table)	\$.17
I. Multiply "G" times "H"	\$21.42
J. Multiply "I" by 12	\$257.04
K. Enter the pay cycle	24
L. Divide "J" by "K"; This is your cost per paycheck	\$10.71

### Benefit and Premium Calculation Worksheet

A. Enter your annual salary*	
B. Determine the amount of coverage you want: Enter 1 for one times salary, 2 for two times salary, 3 for three times salary	
C. Multiply "A" times "B"	
D. Round "C" up to the next higher \$1,000	
E. Enter the Maximum coverage amount (3.00 times "A" rounded up to the next higher \$1,000, or \$500,000, whichever is less)	
F. Enter the lesser of "D" or "E"; This is your benefit amount	
G. Divide "F" by 1,000	
H. Enter the rate for your age (from the Age/Rate Table)	
I. Multiply "G" times "H"	
J. Multiply "I" by 12	
K. Enter the pay cycle	24
L. Divide "J" by "K"; This is your cost per paycheck	

\* If you are uncertain what your current annual salary is, please consult your employer.

### To enroll for Voluntary Term Life coverage

- 1) Indicate the amount of coverage you want by checking the appropriate box in the Voluntary Term Life Benefit Amount section on your enrollment form.
- 2) Enter the amount from line "K" in your worksheet into the Voluntary Term Life Premium Amount section on your enrollment form.

## **COVERAGE SELECTION AND PREMIUM CALCULATION - DEPENDENTS**

*Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.*

### **To select a coverage amount/benefit and calculate the premium for dependent spouse coverage, do the following:**

- 1) Locate the benefit amount you want to select for your spouse from the top row of the premium table. The benefit amount must be in an increment of \$5,000 (ex. \$15,000, \$20,000 or \$25,000). Refer to the Coverage Guidelines section for minimums and maximums, if needed.
- 2) **Your spouse's rate is based on your spouse's age**, so find your spouse's age bracket in the far left column of the Spouse Premium Table.
- 3) The premium amount is found in the box where the row (the age) and the column (benefit amount) intersect.
- 4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life and AD&D section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want \$100,000 in coverage, you obtain your premium amount by multiplying the rate for \$50,000 times 2.

### **To select a coverage amount/benefit and calculate the premium for dependent child coverage, do the following:**

- 1) Locate the benefit amount you want to select for your child(ren) from the top row of the premium table. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
- 2) The premium amount is found in the box below the benefit amount.
- 3) Enter the benefit and premium amounts for your child(ren) into their respective areas in the Voluntary Life and AD&D section of your enrollment form.

\*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

# ***Short Term Disability*** **&** ***Long Term Disability***

Mutual of Omaha

*(for Employees with more than 1 year of service)*



# SHORT-TERM DISABILITY INSURANCE

## BENEFITS SUMMARY



### For Employees of Graduate School USA

#### **ELIGIBILITY - ALL OTHER ELIGIBLE EMPLOYEES**

<b>Eligibility Requirement</b>	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
<b>Minimum Work Hours</b>	You must be working a minimum of 40 hours per week to be eligible for coverage.
<b>Coverage Payment</b>	Your employer pays 100% of the premium for this coverage.

#### **BENEFITS**

<b>Benefits Begin (Elimination Period)</b>	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: <ul style="list-style-type: none"> <li>▪ On the 1st day of your disabling injury.</li> <li>▪ On the 8th day of your disabling illness.</li> </ul>
<b>Weekly Benefit</b>	Your benefit is equivalent to 66 2/3% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount.
<b>Maximum Benefit Period</b>	Short-term disability benefits are available for up to 26 weeks .
<b>Maximum Weekly Benefit</b>	\$1,500
<b>Minimum Weekly Benefit</b>	\$25

#### **DEFINITIONS**

<b>Definition of Disability</b>	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
<b>Definition of Weekly Earnings</b>	Weekly earnings is the average gross weekly income you receive from your employer for the year immediately prior to the onset of disability as verified by your W-2 form, which is used to determine your benefit in the event of a claim.

#### **FEATURES**

<b>Partial Disability Benefits</b>	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
<b>Vocational Rehabilitation Benefit</b>	If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a weekly benefit increase of 5%.
<b>Waiver of Premium</b>	The premium for your short-term disability coverage is waived while you are receiving benefits.

*Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.*

#### **EXCLUSIONS & LIMITATIONS**

<b>Pre-existing Conditions Limitation</b>	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 12 months prior to coverage are excluded.
<b>Other Exclusions</b>	Information about other exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.

*This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by Mutual of Omaha. Short-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.*

# LONG-TERM DISABILITY INSURANCE

## BENEFITS SUMMARY



### For Employees of Graduate School USA

<b>ELIGIBILITY - ALL OTHER ELIGIBLE EMPLOYEES</b>	
<b>Eligibility Requirement</b>	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
<b>Minimum Work Hours</b>	You must be working a minimum of 40 hours per week to be eligible for coverage.
<b>Coverage Payment</b>	Your employer pays 100% of the premium for this coverage.
<b>BENEFITS</b>	
<b>Benefits Begin (Elimination Period)</b>	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin 180 days after the onset of your disabling injury or illness.
<b>Monthly Benefit</b>	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources.
<b>Maximum Benefit Period</b>	If you become disabled prior to age 62, benefits are payable to age 65 or your Social Security Normal Retirement Age. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
<b>Maximum Monthly Benefit</b>	\$5,000
<b>Minimum Monthly Benefit</b>	\$100 / 10%
<b>DEFINITIONS</b>	
<b>Definition of Disability</b>	<p>Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are:</p> <ul style="list-style-type: none"> <li>▪ Prevented from performing at least one of the material duties of your regular occupation during the first 36 months of disability and after 36 months are unable to perform all of the material duties of any gainful occupation; and</li> <li>▪ During the first 36 months of disability are unable to generate current earnings which exceed 99% of your monthly earnings from your regular occupation, and after 36 months if partially disabled, are unable to generate current earnings which exceed 85% of your monthly earnings from any gainful occupation.</li> </ul> <p>You can be totally or partially disabled during the elimination period.</p>
<b>Definition of Monthly Earnings</b>	Monthly earnings is the average gross monthly income you receive from your employer for the year immediately prior to the onset of disability as verified by your W-2 form, which is used to determine your benefit in the event of a claim. If employed less than one year, monthly earnings is the average income received for the months worked.
<b>FEATURES</b>	
<b>Partial Disability Benefits</b>	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
<b>Vocational Rehabilitation Benefit</b>	If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a monthly benefit increase of 5%.
<b>Survivor Benefit</b>	If you pass away while receiving long-term disability benefits, your benefits will be provided to your beneficiaries for a period of time after your death.
<b>Waiver of Premium</b>	The premium for your long-term disability coverage is waived while you are receiving benefits.
<b>Employee Assistance Program</b>	The EAP program provides you and your loved ones access to trained professionals and resources for assistance with personal and workplace issues.
<b>Alcohol &amp; Drug Abuse</b>	For disabilities related to drug and alcohol abuse, benefits are available for up to 24 months.
<b>Mental Disorders</b>	For disabilities related to mental disorders, benefits are available for up to 24 months.

## FEATURES (CONTINUED)

*Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.*

## EXCLUSIONS & LIMITATIONS

<b>Pre-existing Conditions Exclusion</b>	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 3 months prior to coverage are excluded.
<b>Other Exclusions</b>	Information about other exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.

*This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by Mutual of Omaha. Long-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.*

***Voluntary***  
***Short Term Disability***  
**&**  
***Voluntary***  
***Long Term Disability***

*(for Employees with less than 1 year of service)*

Mutual of Omaha



# VOLUNTARY SHORT-TERM DISABILITY INSURANCE

## BENEFITS SUMMARY



### For Employees of Graduate School USA

#### **ELIGIBILITY - ALL ELIGIBLE EMPLOYEES WITH LESS THAN 1 YEAR OF SERVICE**

<b>Eligibility Requirement</b>	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
<b>Minimum Work Hours</b>	You must be working a minimum of 40 hours per week to be eligible for coverage.
<b>Coverage Payment</b>	You pay 100% of the premium for this coverage through easy payroll deduction.

#### **BENEFITS**

<b>Benefits Begin (Elimination Period)</b>	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: <ul style="list-style-type: none"> <li>▪ On the 1st day of your disabling injury.</li> <li>▪ On the 8th day of your disabling illness.</li> </ul>
<b>Weekly Benefit</b>	Your benefit is equivalent to 66 2/3% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount.
<b>Maximum Benefit Period</b>	Short-term disability benefits are available for up to 26 weeks .
<b>Maximum Weekly Benefit</b>	\$1,500
<b>Minimum Weekly Benefit</b>	\$25

#### **DEFINITIONS**

<b>Definition of Disability</b>	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
<b>Definition of Weekly Earnings</b>	Weekly earnings is the average gross weekly income you receive from your employer for the year immediately prior to the onset of disability as verified by your W-2 form, which is used to determine your benefit in the event of a claim.

#### **FEATURES**

<b>Partial Disability Benefits</b>	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
<b>Vocational Rehabilitation Benefit</b>	If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a weekly benefit increase of 5%.
<b>Waiver of Premium</b>	The premium for your short-term disability coverage is waived while you are receiving benefits.

*Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.*

#### **EXCLUSIONS & LIMITATIONS**

<b>Pre-existing Conditions Limitation</b>	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 12 months prior to coverage are excluded.
<b>Other Exclusions</b>	Information about other exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.

*This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail.*

*Benefits availability is subject to final acceptance and approval of the group application by Mutual of Omaha. Short-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.*

## VOLUNTARY SHORT-TERM DISABILITY BENEFIT AND PREMIUM CALCULATION

Calculate your benefit and premium for voluntary short-term disability coverage in the worksheet below, using the example as a guide.

### Benefit and Premium Calculation Example

*This example is for an employee earning \$42,000 a year.*

A. Enter your annual salary	\$42,000.00
B. Enter the Weekly Benefit percentage	66 2/3%
C. Multiply "A" times "B"	\$27,997.20
D. Divide "C" by 52	\$538.41
E. Enter the Maximum Weekly Benefit	\$1500.00
F. Enter the lesser of "D" or "E"; This is your benefit amount	\$538.41
G. Divide "F" by \$10	\$53.84
H. Multiply "G" times \$.340	\$18.31
I. Multiply "H" by 12	\$219.67
J. Enter the annual pay cycle	24
K. Divide "I" by "J"; This is your premium (cost per paycheck)	\$9.15

### Benefit and Premium Calculation Worksheet

A. Enter your annual salary*	
B. Enter the Weekly Benefit percentage	66 2/3%
C. Multiply "A" times "B"	
D. Divide "C" by 52	
E. Enter the Maximum Weekly Benefit	\$1500.00
F. Enter the lesser of "D" or "E"; This is your benefit amount	
G. Divide "F" by \$10	
H. Multiply "G" times \$.340	
I. Multiply "H" by 12	
J. Enter the annual pay cycle	24
K. Divide "I" by "J"; This is your premium (cost per paycheck)	

\*If you are uncertain what your current annual salary is, please consult your employer.

#### To enroll for short-term disability coverage:

- 1) Enter the amount from line "F" in your worksheet into the Voluntary Short-Term Disability Benefit Amount section on your enrollment form.
- 2) Enter the amount from line "K" in your worksheet into the Voluntary Short-Term Disability Premium Amount section on your enrollment form.

# VOLUNTARY LONG-TERM DISABILITY INSURANCE

## BENEFITS SUMMARY



### For Employees of Graduate School USA

<b>ELIGIBILITY - ALL ELIGIBLE EMPLOYEES WITH LESS THAN 1 YEAR OF SERVICE</b>	
<b>Eligibility Requirement</b>	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
<b>Minimum Work Hours</b>	You must be working a minimum of 40 hours per week to be eligible for coverage.
<b>Coverage Payment</b>	You pay 100% of the premium for this coverage through easy payroll deduction.
<b>BENEFITS</b>	
<b>Benefits Begin (Elimination Period)</b>	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin 180 days after the onset of your disabling injury or illness.
<b>Monthly Benefit</b>	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources.
<b>Maximum Benefit Period</b>	If you become disabled prior to age 62, benefits are payable to age 65 or your Social Security Normal Retirement Age. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
<b>Maximum Monthly Benefit</b>	\$5,000
<b>Minimum Monthly Benefit</b>	\$100 / 10%
<b>DEFINITIONS</b>	
<b>Definition of Disability</b>	<p>Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are:</p> <ul style="list-style-type: none"> <li>▪ Prevented from performing at least one of the material duties of your regular occupation during the first 36 months of disability and after 36 months are unable to perform all of the material duties of any gainful occupation; and</li> <li>▪ During the first 36 months of disability are unable to generate current earnings which exceed 99% of your monthly earnings from your regular occupation, and after 36 months if partially disabled, are unable to generate current earnings which exceed 85% of your monthly earnings from any gainful occupation.</li> </ul> <p>You can be totally or partially disabled during the elimination period.</p>
<b>Definition of Monthly Earnings</b>	Monthly earnings is the average gross monthly income you receive from your employer for the year immediately prior to the onset of disability as verified by your W-2 form, which is used to determine your benefit in the event of a claim. If employed less than one year, monthly earnings is the average income received for the months worked.
<b>FEATURES</b>	
<b>Partial Disability Benefits</b>	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
<b>Vocational Rehabilitation Benefit</b>	If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a monthly benefit increase of 5%.
<b>Survivor Benefit</b>	If you pass away while receiving long-term disability benefits, your benefits will be provided to your beneficiaries for a period of time after your death.
<b>Waiver of Premium</b>	The premium for your long-term disability coverage is waived while you are receiving benefits.
<b>Employee Assistance Program</b>	The EAP program provides you and your loved ones access to trained professionals and resources for assistance with personal and workplace issues.
<b>Alcohol &amp; Drug Abuse</b>	For disabilities related to drug and alcohol abuse, benefits are available for up to 24 months.
<b>Mental Disorders</b>	For disabilities related to mental disorders, benefits are available for up to 24 months.

## FEATURES (CONTINUED)

*Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.*

## EXCLUSIONS & LIMITATIONS

<b>Pre-existing Conditions Exclusion</b>	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 3 months prior to coverage are excluded.
<b>Other Exclusions</b>	Information about other exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.

*This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by Mutual of Omaha. Long-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.*

## VOLUNTARY LONG-TERM DISABILITY BENEFIT AND PREMIUM CALCULATION

Calculate your benefit and premium for voluntary long-term disability coverage in the worksheet below, using the example as a guide.

### Benefit and Premium Calculation Example

*This example is for an employee earning \$42,000 a year.*

A. Enter your annual salary	\$42,000.00
B. Enter the Monthly Benefit percentage	60%
C. Multiply "A" times "B"	\$25,200.00
D. Divide "C" by 12	\$2,100.00
E. Enter the Maximum Monthly Benefit	\$5,000.00
F. Enter the lesser of "D" or "E"; This is your benefit amount	\$2,100.00
G. Divide "F" by 60%	\$3,500.00
H. Multiply "G" by 12	\$42,000.00
I. Multiply "H" by \$.0018	\$75.60
J. Enter the annual pay cycle	24
K. Divide "I" by "J"; This is your premium (cost per paycheck)	\$3.15

### Benefit and Premium Calculation Worksheet

A. Enter your annual salary*	
B. Enter the Monthly Benefit percentage	60%
C. Multiply "A" times "B"	
D. Divide "C" by 12	
E. Enter the Maximum Monthly Benefit	\$5,000.00
F. Enter the lesser of "D" or "E"; This is your benefit amount	
G. Divide "F" by 60%	
H. Multiply "G" by 12	
I. Multiply "H" by \$.0018	
J. Enter the annual pay cycle	24
K. Divide "I" by "J"; This is your premium (cost per paycheck)	

\*If you are uncertain what your current annual salary is, please consult your employer.

### To enroll for long-term disability coverage:

- 1) Enter the amount from line "F" in your worksheet into the Voluntary Long-Term Disability Benefit Amount section on your enrollment form.
- 2) Enter the amount from line "K" in your worksheet into the Voluntary Long-Term Disability Premium Amount section on your enrollment form.

# ***Flexible Spending Account***

TASC



# Advantages of a Flexible Spending Account (FSA)

## A valuable pre-tax benefit with innovative services!

**FlexSystem FSA increases your take-home pay by reducing your taxable income.** A Flexible Spending Account (FSA) allows you to save up to 30% on your eligible healthcare and/or dependent care expenses every year by using pre-tax dollars.

Consider how much you spend on healthcare and/or dependent care expenses for you and your qualified dependents in one year:

- prescription drugs/medications.
- medical/dental office visit co-pays.
- eye exams and prescription glasses/lenses.
- vaccinations.
- daycare tuition.

Why not reduce these expenses by using pre-tax dollars instead of after-tax dollars? With rising healthcare costs, ***every penny counts!*** By using pre-tax dollars, you are taxed on a lower gross salary, thereby saving money that would otherwise be spent on federal, state and FICA taxes, and thereby you ***increase your take home pay!***

Employee salary reductions to a medical Flexible Spending Account (FSA) are limited to \$2,500 per Plan Year, indexed for inflation. Check with your employer for your Plan's maximum annual election amount.

### How FlexSystem Works

FlexSystem FSA is offered through your employer and is administered by TASC. When you choose to enroll in a FlexSystem FSA Healthcare and/or Dependent Care, you choose the dollar amount you want to contribute to each account based on your estimated expenses for the upcoming Plan Year. Your contributions will be deducted in equal amounts from each paycheck, **pre-tax**, throughout the Plan Year. ***The more you contribute to these accounts, the more you save by paying less in taxes!***

Your total Healthcare FSA annual contribution amount is available immediately at the start of the Plan Year; Dependent Care FSA funds are available up to the current account balance only.

### Reimbursements and the TASC Card

As you incur eligible expenses, simply swipe your TASC Card. The card automatically pays for and substantiates most eligible expenses at the point of purchase. If you do not use the TASC Card to pay for an eligible expense, simply submit a request for reimbursement via the MyTASC Mobile App, online Request for Reimbursement Wizard in MyTASC, text message, fax, or mail.

Your reimbursement is deposited in your MyCash account. You can access your MyCash funds in three ways: (1) swipe your TASC Card at any merchant that accepts major credit cards, (2) withdraw at an ATM using your TASC Card (with PIN), or (3) transfer to a personal bank account from MyCash Manager within MyTASC.

### FlexSystem Healthcare FSA FlexSystem Dependent Care FSA

#### Pre-Tax Savings Example

	Without FSA	With FSA
Gross Monthly Pay:	\$3,500	\$3,500
Pre-Tax Contributions		
Medical/Dental Premiums	\$0	-\$125
Medical Expenses	\$0	-\$75
Dependent Care Expenses	\$0	-\$400
TOTAL:	\$0	<b>-\$600</b>
Taxable Monthly Income	<b>\$3,500</b>	<b>\$2,900</b>
Taxes (federal, state, FICA):	-\$968	-\$802
Out-of-pocket Expenses:	<b>-\$600</b>	\$0
<b>Monthly Take-home Pay:</b>	<b>\$1,932</b>	<b>\$2,098</b>

***Net Increase in Take-Home Pay = \$166/mo!***

For illustration only. Actual dollar amounts may vary.

## FSA Eligible Expenses

FlexSystem FSA funds may only be used for eligible expenses under your healthcare FSA and/or dependent care FSA. Some eligible expenses include:

- Medical care services      • Prescriptions
- Dental care services      • Certain over-the-counter medications
- Vision care expenses      • Daycare tuition

More detailed lists can be found at [www.irs.gov](http://www.irs.gov) in IRS Publications 502 & 503.

Please note insurance premiums are NOT eligible for reimbursement.

*33 million Americans  
save up to 30%  
every year  
by participating  
in an FSA.*

2009 Nielson Consumer Research

## Multiple Methods for Account Management

You may use any of the following self-service options to access your FlexSystem accounts and TASC Card transactions:

- **MyTASC Online:** [www.tasconline.com](http://www.tasconline.com)
- **MyCash Manager:** within MyTASC at [www.tasconline.com](http://www.tasconline.com)
- **MyTASC Mobile App:** free download at [www.tasconline.com/mobile](http://www.tasconline.com/mobile)
- **MyTASC Text Messaging:** elect through your MyTASC account online

### *Online enrollment and account management.*

***Online tax-savings calculator to help determine how much to contribute.***

***Convenient pre-tax payroll deductions.***

***Benefits debit card for eligible purchases.***

***Mobile app for account access on the go.***

***Multiple self-service tools.***

***Fast reimbursements.***

### **Important Considerations**

#### ***FSA Funds do not Rollover:***

It is important to be conservative in making elections because any unused funds left in your FSA at the close of the Plan Year are not refundable to you. (The only exception to this rule is for the Healthcare FSA where funds may carryover to the next Plan Year's healthcare FSA (up to \$500) when elected by your employer.) You are urged to take precautionary steps, such as tracking account balances on the FlexSystem website and/or using the Interactive Voice Response System, to avoid having funds remaining in your account at year-end.

#### ***Changing Elections During the Plan Year:***

You may change your FSA elections during the Plan year only if you experience a change of status such as:

- a marriage or divorce
- birth or adoption of a child, or
- a change in employment status

Refer to the Change of Election Form (available from your employer) for a complete list of circumstances acceptable for changing elections mid-year.

*Sign up for FlexSystem and keep more money in your pocket!*





# BE MONEY SMART.

Put up to \$500 in a medical FSA with **no risk** of losing it at year's end.

## Putting Money in an FSA is Smart and Safe.

Everybody has medical bills, right? Expenses for prescriptions, co-pays, doctor's office visits, glasses and contacts, and dental work add up over the course of a year. With an FSA, you can **save 30%** on these expenses by paying for them with pre-tax dollars.

### Keep your money, yours.

It can be a challenge to estimate how much money to set aside each year in an FSA. But now you have a \$500 safety net! New government regulations allow you to carryover up to \$500 (if allowed by your employer) of your unused medical FSA funds from year to year.

### How much will you elect this year?

Enrolling in an FSA is a savvy way to save money on health expenses. Everyone who anticipates any out-of-pocket medical expenses should take advantage of the benefits of an FSA. There is no risk to contribute at least \$500. At the end of the year, if your medical expenses are below that amount, you can carryover any amount up to \$500 and use it next year—with no cost or penalties.

If you've participated in an FSA in the past, you already know how much you can save. And now you're safe to increase your annual election by \$500, knowing if you don't use it this year, you can carryover a maximum of \$500 to the next year with **no risk of forfeiture** at the Plan Year end.

FSA contributions are deducted pre-tax from your payroll. The more you elect, the more your taxable income is reduced—which means more take-home pay!

*Be Smart! Enroll in a medical FSA today.*

Other FSA benefits may be offered by your employer. Ask your employer for more information.

### FlexSystem® FEATURES:

- TASC Card pays for and substantiates most eligible expenses at the point of purchase.
- Reimbursements are deposited in MyCash and accessible via the TASC Card.
- Mobile App, texting, and 24-hour phone system for easy access on the go!
- Convenient account management, including online reimbursement requests.
- Dedicated customer support team.





## MyCash Reimbursement Account

### Convenient access to your reimbursement funds

**MyCash is an individual cash account that securely holds your reimbursement funds until you spend or move them.**

On those rare occasions when you do not use your TASC Card to pay for an eligible employee benefits expense, simply submit a request for reimbursement via the MyTASC Mobile app or online Request for Reimbursement Wizard in MyTASC ([www.tasconline.com](http://www.tasconline.com)).

Requests are processed daily and approved reimbursements are deposited directly into your MyCash account—usually within 24-48 hours. Reimbursements are quick—even faster than with direct deposit!

Then you choose how to use your MyCash funds. There are no restrictions on type of expense or merchant. These are your reimbursement funds and can be spent just like cash everywhere major credit cards are accepted.



*What are you going to do with your MyCash funds? It's your choice!*

#### Access your MyCash funds in three ways:

- SWIPE your TASC Card at any merchant that accepts major credit cards.
- WITHDRAW at an ATM (with a PIN) using your TASC Card.
- TRANSFER to a personal bank account via MyCash Manager.

*"I submitted a manual request for reimbursement and about a day later my reimbursement was ready for me in my MyCash account. I was able to use my TASC Card at the grocery store to pay for my purchase using my MyCash. The whole process was so easy and convenient!"*

*—Shari, FlexSystem Participant*

#### Join the MyCash Movement

Hundreds of thousands of FlexSystem Participants are enjoying the convenience of MyCash in their daily lives! You can, too.

*"With MyCash, my money is back in my hands in a day or two and I don't ever have to make a trip to the bank for a deposit or withdrawal."*

*—Patti, FlexSystem Participant*

#### Did you know...

- 93% of FlexSystem Participants have the TASC Card.
- 95% of TASC Card holders have access to MyCash.
- While 84% of reimbursements are paid via the TASC Card at the point of purchase, 56% of Participants who submit manual requests for reimbursement and receive MyCash disbursements choose to access their MyCash with the swipe of their TASC Card.
- Participants swipe their cards for MyCash transactions more than 800 times a day!



## New to FlexSystem or MyCash?

All new FlexSystem Participants will receive reimbursement disbursements via MyCash. They may access their MyCash funds via the swipe of their TASC Card at any merchant or ATM that accepts major credit cards, or transfer via the MyCash Manager in MyTASC.

When MyCash is activated for existing Participants, the Participants' disbursement schedules will remain unchanged. If a Participant currently receives disbursements via direct deposit or check, the Participant will continue to get his/her reimbursements by direct deposit or check until the Participant changes his/her MyCash Schedule.

*To move from an automatic transfer (direct deposit or paper check) to MyCash via the TASC Card, log in to MyTASC ([www.tasconline.com](http://www.tasconline.com)), click MyCash Manager, select MyCash Schedules from the dropdown menu, and click the black X next to your current schedule. Your next reimbursement will be deposited in MyCash.*

## MyCash Manager

**Log in to your MyTASC account and click MyCash Manager.**

It's easy to view and manage your MyCash funds from your private MyCash Manager, a state-of-the-art web tool within MyTASC designed exclusively for the management of your MyCash funds.

The screenshot shows the MyTASC MyCash Manager interface. At the top, there are links for 'MyCash' and 'Help'. Below that, a message says 'MyCash Available Balance: \$473.00 Current activity may not be reflected in the current balance displayed.' Under 'Recent Activity', it shows a table with columns: Date, Description, Card Number, Amount, and Balance. A single row is shown: '10/28/2011 Deposit: FlexSystem Reimbursement' with '\$473.00' in all other columns. At the bottom of the interface, there are links for 'DAVID A BARAN', 'Make a Transfer', and 'Request ATM PIN'. A note states: 'Note: Recent Activity may not be reflected in the current balance displayed.'

- View recent MyCash reimbursements, transfers, ATM withdrawals, and/or TASC Card transactions.
- View TASC Card information, reissue a card, request a PIN, view allowed benefits, request a dependent card, and view card history.
- Save bank account details to easily schedule transfers from MyCash to a personal bank account.
- Make quick, one-time, recurring, or automatic transfers to a personal checking or savings account.

*When combining healthcare and general items in one transaction, the TASC Card is smart enough to know that eligible items are paid from your MyBenefits account and ineligible items are paid from MyCash.*

**Get it Faster!  
JOIN THE MYCASH  
MOVEMENT**

## Making MyCash Transfers

The industry-exclusive tools in MyCash Manager let you make transfers how and when it's convenient for you!

Using a robust set of options, you may transfer funds from MyCash to a personal savings or checking account any time from anywhere.

The form is titled 'Choose Transfer Method: Jane's checking'. It has sections for 'Account Information' (Account Type: Checking, Routing Number: \*\*\*\*8886, Routing Bank: ANY BANK USA, Account Number: \*\*\*0611, Re-enter Account Number: \*\*\*0611, Account Name (Optional): Jane's checking), 'Transfer Options' (radio buttons for One Time, Recurring, Automatic), and 'Transfer Type' (radio buttons for By Date, By Amount).

Choose from four types of transfers:

### Quick Transfer

A single, instant transfer with no bank account details saved unless a saved bank account is selected.

### One Time Transfer

A single transfer scheduled in advance using saved or new bank account details, based on date or amount.

### Recurring Transfer

Multiple transfers scheduled in advance using saved or new bank account details, based on date or amount.

### Automatic Transfer

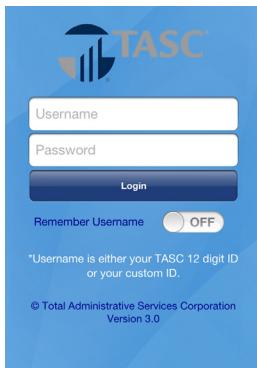
Repeated transfers scheduled to occur to a selected bank account every time funds enter MyCash (same as direct deposit).





## MyTASC Mobile App

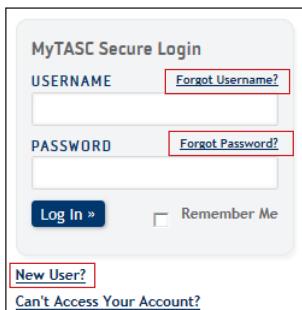
Manage your FlexSystem account on the go!



### Login

Enter your username (or 12-digit TASC ID) and password.

NOTE: If you have forgotten your username or password, visit [www.tasconline.com](http://www.tasconline.com) and click Forgot Username or Forgot Password in the MyTASC Secure Account Login box. If you are a new user, click New User.



### View Account Summary and Balances

View your account summary and your Plan balances for all elected benefits accounts, including MyCash, and active or closing accounts. Simply select the appropriate button at the bottom of the screen.



### Plan Transaction History

View transaction history, including service provider, service date, and reimbursement amount for any active or closing benefits account. Select accounts by using the drop down menu at the top of the screen, and toggle between active and closing accounts using the buttons at the bottom of the screen.



### Request Details

View individual request details, including request ID, payment status, and submission date.

**FREE DOWNLOAD**  
from Amazon,  
Apple® App Store and  
Google Play for Android™  
for your smartphone  
or tablet.



## Reimbursement Request

To begin your reimbursement request, choose the date of service, benefit type, amount, and service provider from this screen. You may also choose an image to attach to your request, or take a new picture using your smartphone's camera.

**TASC NEVER SLEEPS!**

**FlexSystem makes it easy to request a reimbursement from anywhere at any time.**



### Enter Date of Service

The date must be within the Plan year(s) available and cannot be a future date.

### Enter the Amount

A dollar sign is not needed. Use the Back button to return to the Request for Reimbursement screen. If you are finished, click Save Amount.

### Enter Benefit Type

Benefit type is required and only the benefit types you have elected will be visible.

### Enter Service Provider

The service provider is the name of the person or place where you receive a service or purchased eligible items.

### Submit Receipt

You may attach your receipt directly to the Request for Reimbursement: either take a new photo using your mobile device camera or select an existing image. If you have no receipt, you can obtain and submit it later via your MyTASC account at [www.tasconline.com](http://www.tasconline.com) (click Account Management, Reimbursement).



Visit the TASC Mobile web page  
for more information.  
[www.tasconline.com/mobile](http://www.tasconline.com/mobile)



# Important Contact Information:

- **Carefirst – Medical**
  - [www.carefirst.com](http://www.carefirst.com)
  - Group ID: 16DM
  - Please refer to the number on your ID Card
- **Dominion – Dental Carrier**
  - [www.dominiondental.com](http://www.dominiondental.com)
  - Group ID:
    - Access ePPO: 180808
    - Choice PPO: 180809
  - 888-518-8849 – Member Services
- **Mutual of Omaha – Life & AD&D, Voluntary Life & AD&D, Short Term Disability, Long Term Disability**
  - [www.mutualofomaha.com](http://www.mutualofomaha.com)
  - 800-775-8805 – Life Claims
  - 800-877-5176 – Disability Claims
- **TASC – Flexible Spending Account**
  - [www.tasconline.com](http://www.tasconline.com)
  - 888-460-8005 – Customer Service
- **Gallagher Benefit Services – Benefits Broker**
  - [www.ajg.com](http://www.ajg.com)
  - 301-921-7804
  - Michelle Hall – Account Manager – [michelle\\_hall@ajg.com](mailto:michelle_hall@ajg.com)
  - Kyle Armeny – Account Executive – [kyle\\_armeny@ajg.com](mailto:kyle_armeny@ajg.com)
  - Britton Smith – Benefit Analyst – [britton\\_smith@ajg.com](mailto:britton_smith@ajg.com)

